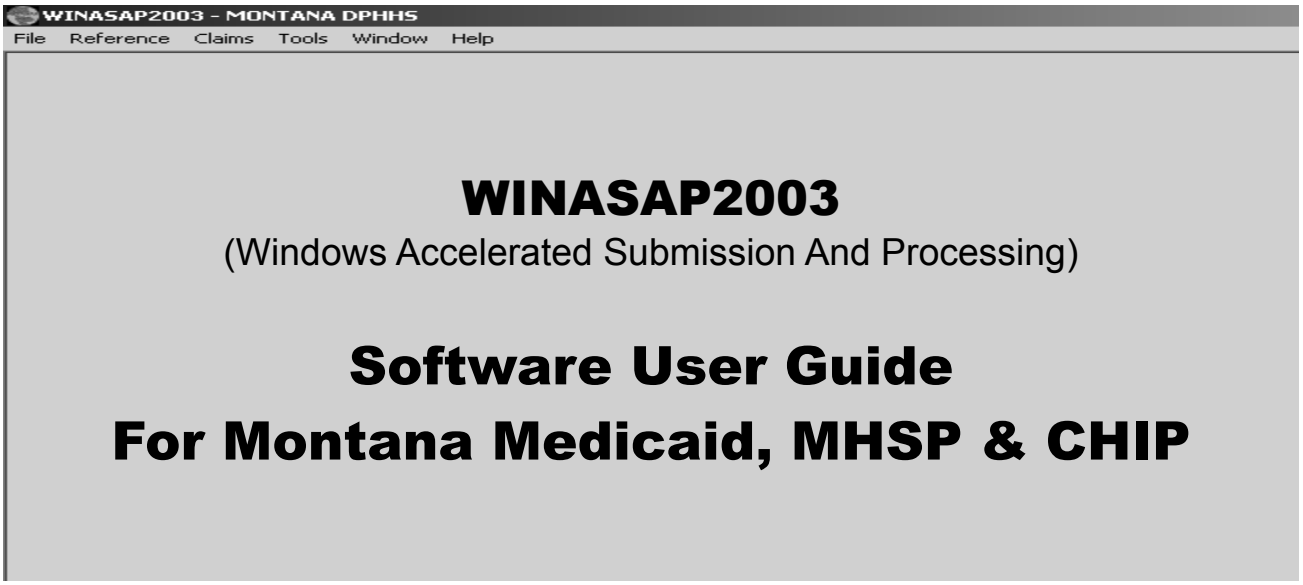


WINASAP2003

(Windows Accelerated Submission And Processing)

Software User Guide
For Montana Medicaid, MHSP & CHIP

Table of Contents

Appendices

A C S®

General Information

- WINASAP does not require an internet connection. The basic requirements are a PC running Windows 98 Second Edition or higher and a standard analog (non-digital) phone line. If possible, you should not be connected to the internet while transmitting WINASAP claims.

- WINASAP is not case sensitive.

- Provider and patient information must be entered in the reference database prior to incorporating into the electronic claim. Procedure, diagnosis, and revenue codes can be entered into reference databases but they do not have to be entered prior to building a claim. These codes can be entered directly into the claim screen.

- Generally, all required fields are underlined on the entry screens, however, a particular claim may require additional information, such as a prior authorization number or PASSPORT number. There are also a few fields that are required, but not underlined. This User Guide identifies all required fields.

- Most Windows-based keyboard commands are available in WINASAP: tab key moves cursor from field to field; shift+tab moves cursor back field to field; control+C is copy command; control+V is paste command; etc.

- The F5 key enters current date in any date field.

- WINASAP will not allow user to save an incomplete provider, patient, or claim entry. A claim must be placed in “Hold” status to save an incomplete entry.

- If user cancels or exits a claim prior to saving, it will be lost. WINASAP does not automatically prompt user to save the claim.

- Users are recommended to keep claim lists as short as possible by deleting old claims on a regular basis. Maintaining large claim lists will adversely affect software performance, i.e., slowing, increased error messages, etc.

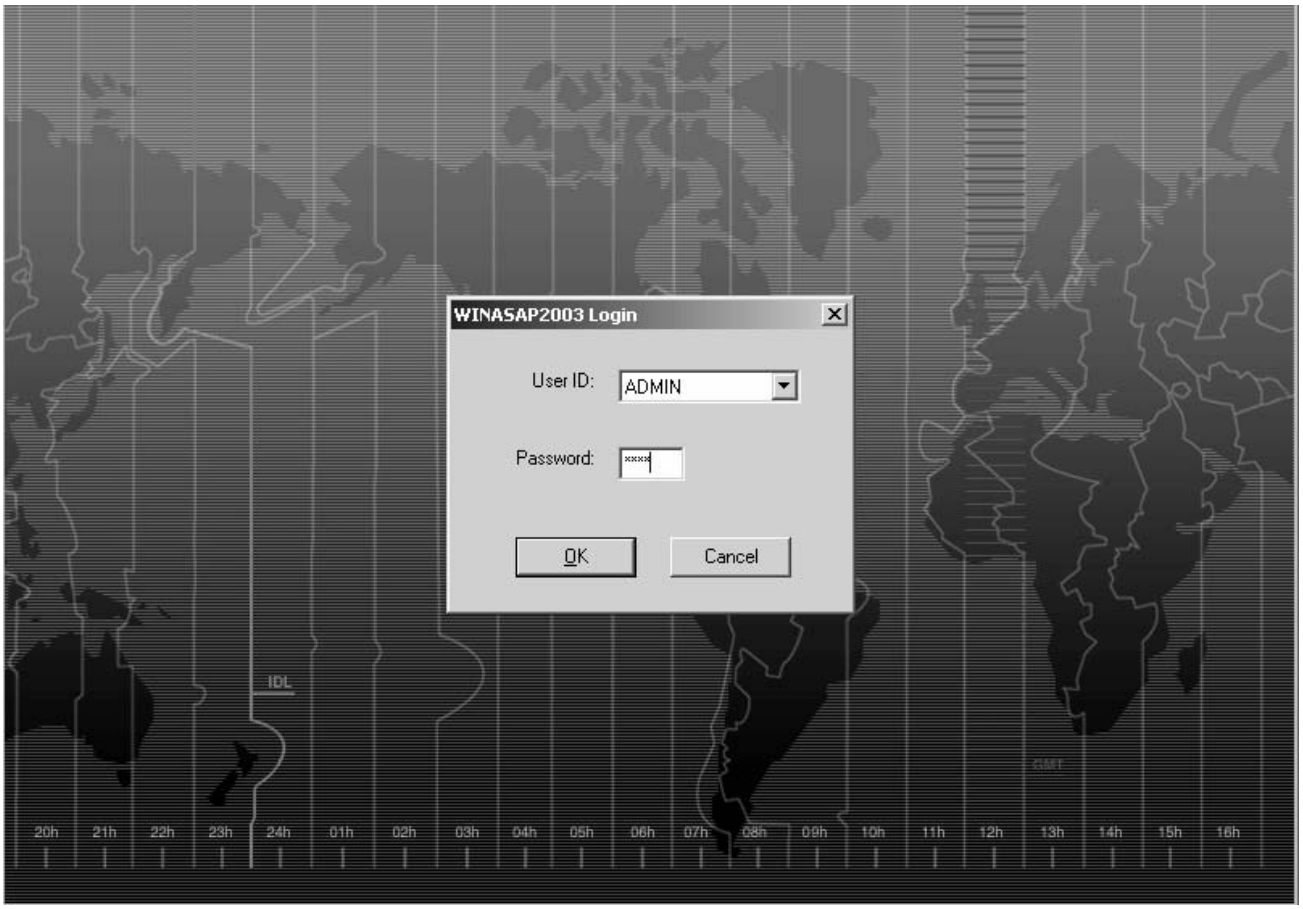
- A hard copy of an individual claim can be printed by selecting “Print” under the “File” pull-down menu while the claim is open.

- Software updates can be downloaded from www.acs-gcro.com.

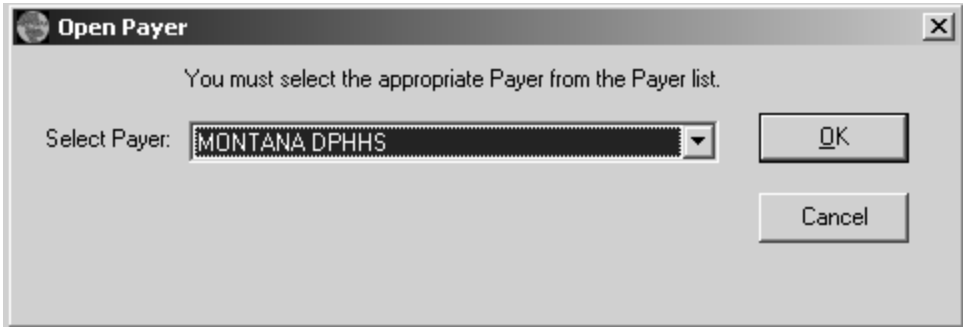
- Questions regarding technical issues pertaining to WINASAP, electronic claims submission, and enrollment should be directed to the EDI call center at 1-800-987-6719.

- Other questions should be directed to ACS Provider Relations at 1-800-624-3958 or 406-442-1837 in Helena or out-of-state.

Initial Set-up

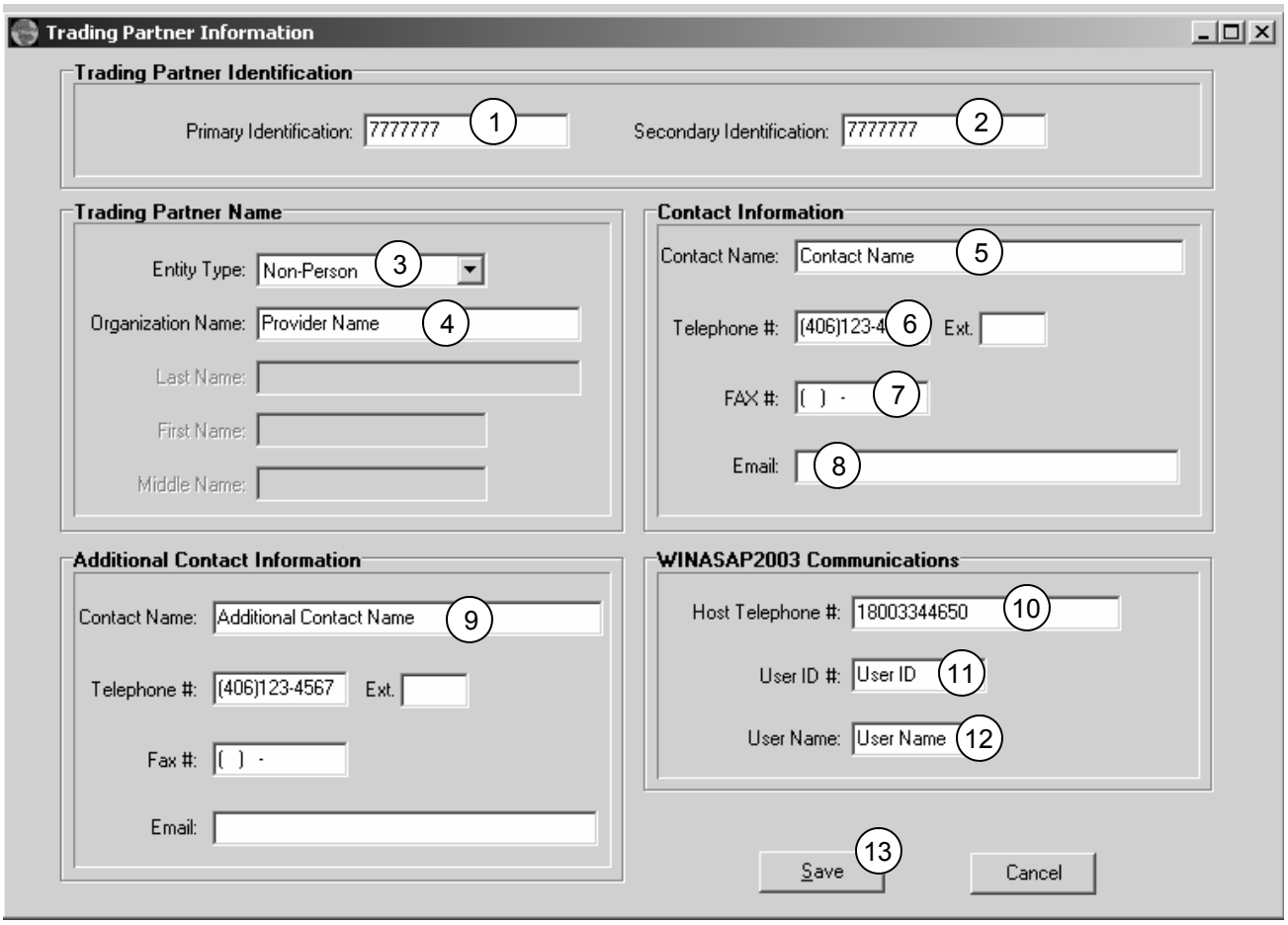


1. Enter default password “asap.”
2. Click “OK.”



At initial setup, WINASAP will prompt you to Select Payer. On the pull-down menu, select “Montana DPHHS” and click “OK.” This is a one-time setup: Every time WINASAP is subsequently opened, Montana DPHHS will be set as the payer.

Trading Partner/Submitter Set-up

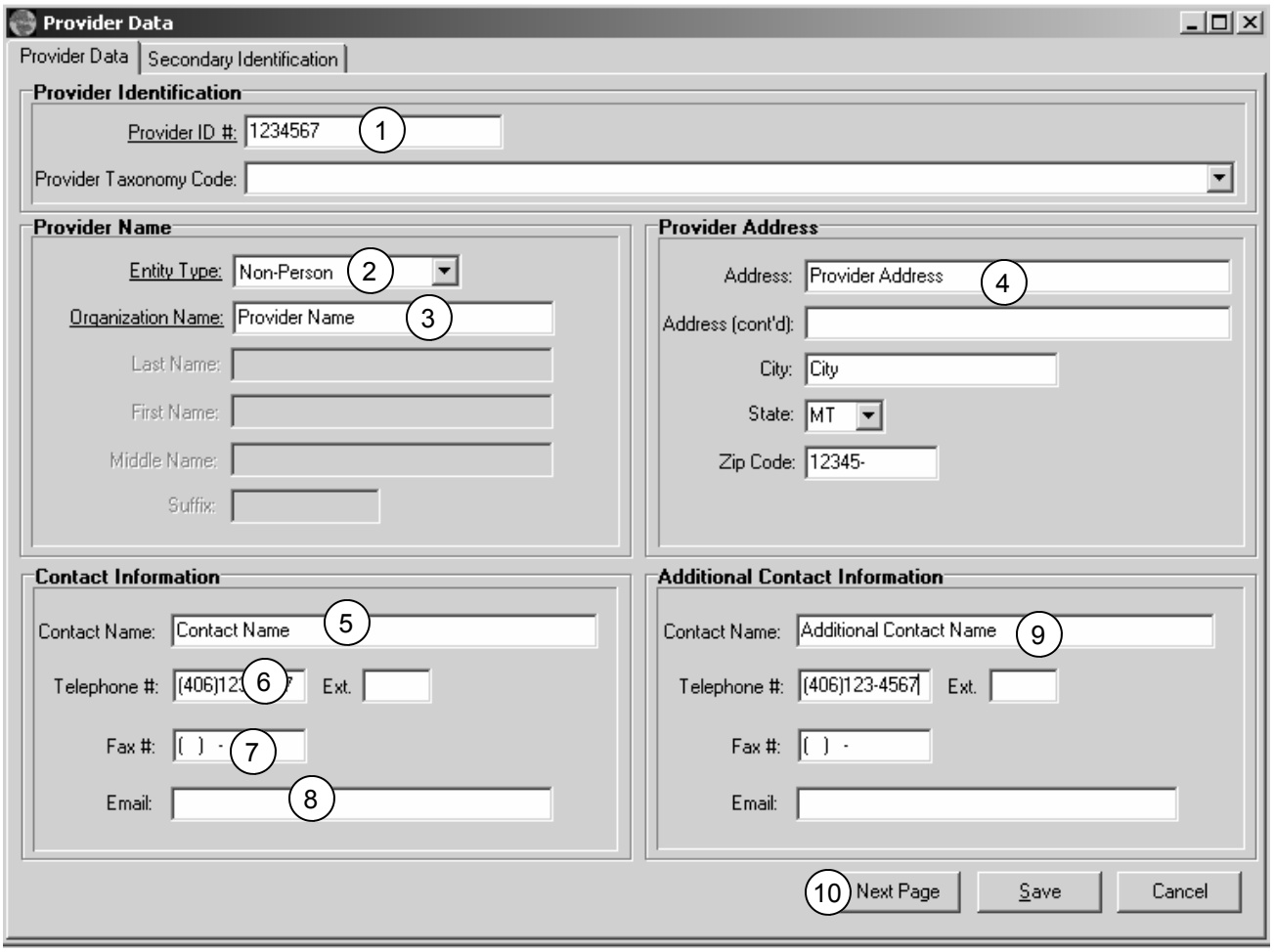


Under the File pull-down menu at the top of the screen, select “Trading Partner.”

1. Under “Primary Identification,” enter your seven-digit Trading Partner/Submitter ID number assigned by EDI (always begins with 77…).
2. Under “Secondary Identification,” enter your seven-digit Trading Partner/Submitter ID number assigned by EDI (always begins with 77…)
3. On the pull-down menu, select Entity Type, either person or non-person.
4. Enter Organization Name. If “person” is selected under Entity Type, enter last name and first name in appropriate fields. (Middle name is optional.)
5. Enter Contact Name (Name of billing person).
6. Enter telephone number.
7. Enter Fax number (optional).
8. Enter e-mail address (optional).
9. Enter Additional (secondary) Contact Information (optional).
10. Enter Host Telephone number (800 number supplied by EDI). Note: If you need to dial a “9,” or other number to connect to an outside line, enter a “9” followed by a comma before the 1-800 number.
11. Enter User ID # (assigned by EDI). Sometimes referred to as “Password.”
12. Enter User Name (assigned by EDI). Sometimes referred to as “Login ID.”
13. When completed, click on “Save.”

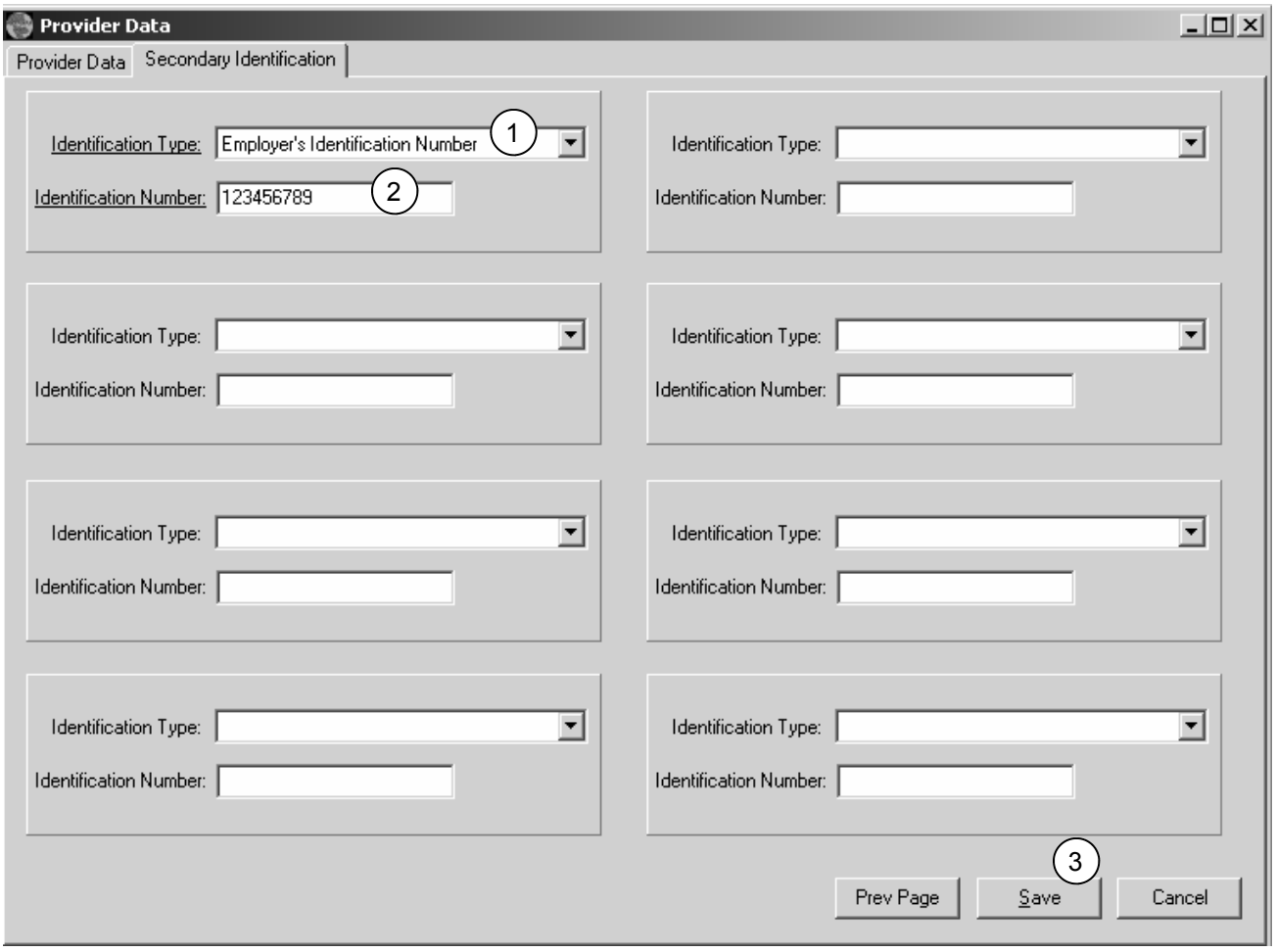
The communications settings for fields 1, 2, 10, 11, & 12, can be found on the Welcome Letter sent by EDI

Entering Provider Data



Under the Reference pull-down menu at top of screen, select “Provider.” This will open the Provider List. Click on “Add” to add a provider to the list.

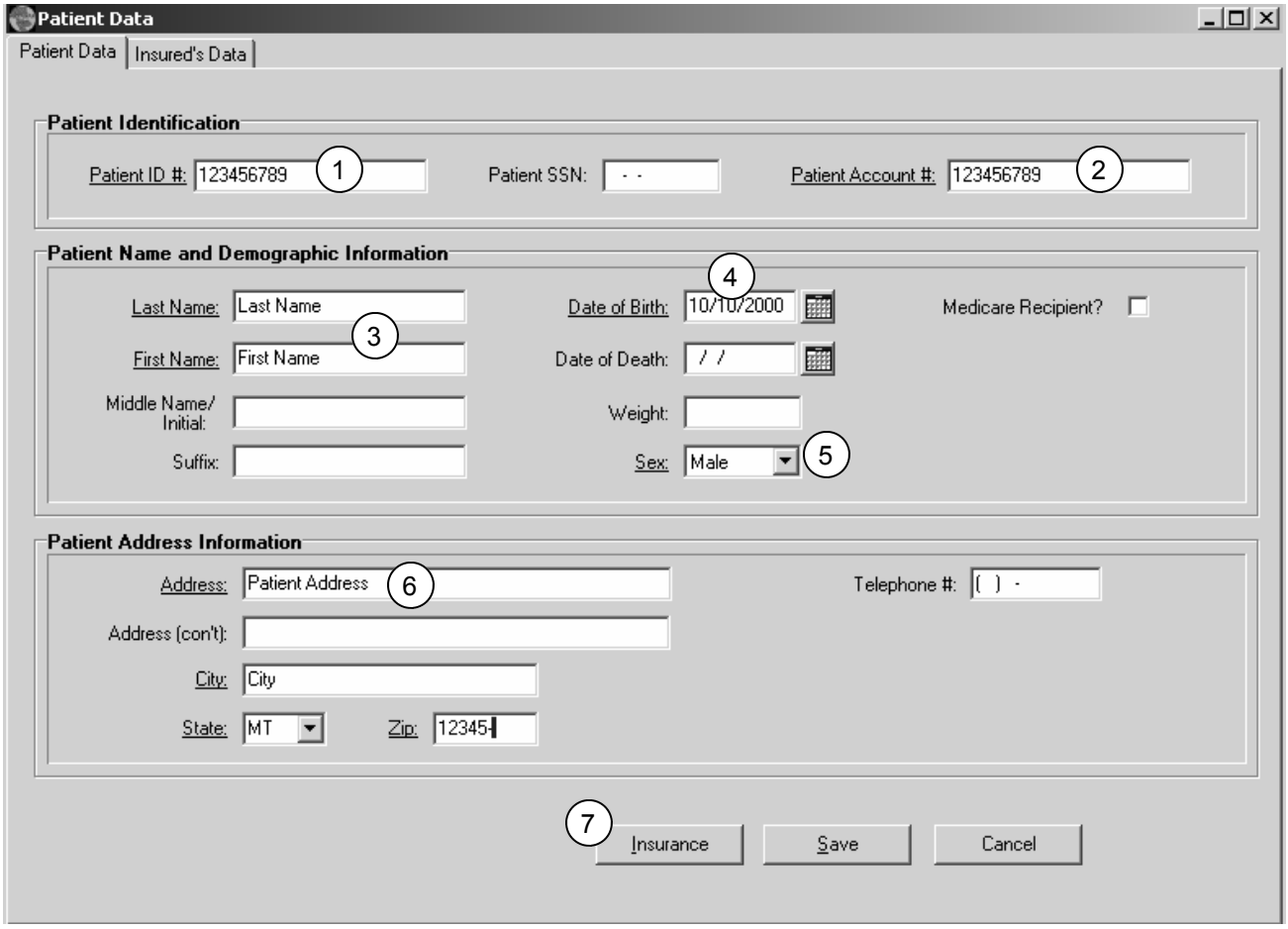
1. Enter the Provider ID number. This is a seven-digit number assigned by ACS/Montana DPHHS. Add leading zeros if needed to make the number seven digits long.
2. On the pull-down menu, select Entity Type, either person or non-person.
3. Enter Organization Name. If “person” is selected under Entity Type, enter last name, first name in appropriate fields. (Middle name/suffix is optional.)
4. Enter Provider Address, including city, state, & zip code.
5. Enter Contact Name (Name of billing person).
6. Enter contact telephone number.
7. Enter contact fax number (optional).
8. Enter contact e-mail address (optional).
9. Enter Additional Contact Information (optional).
10. Click on “Next Page.”



1. Under pull-down menu, select Identification Type, either social security number or EIN/tax ID number.
2. Enter the SSN or EIN number (hyphens can be omitted).
3. Click on “Save.”

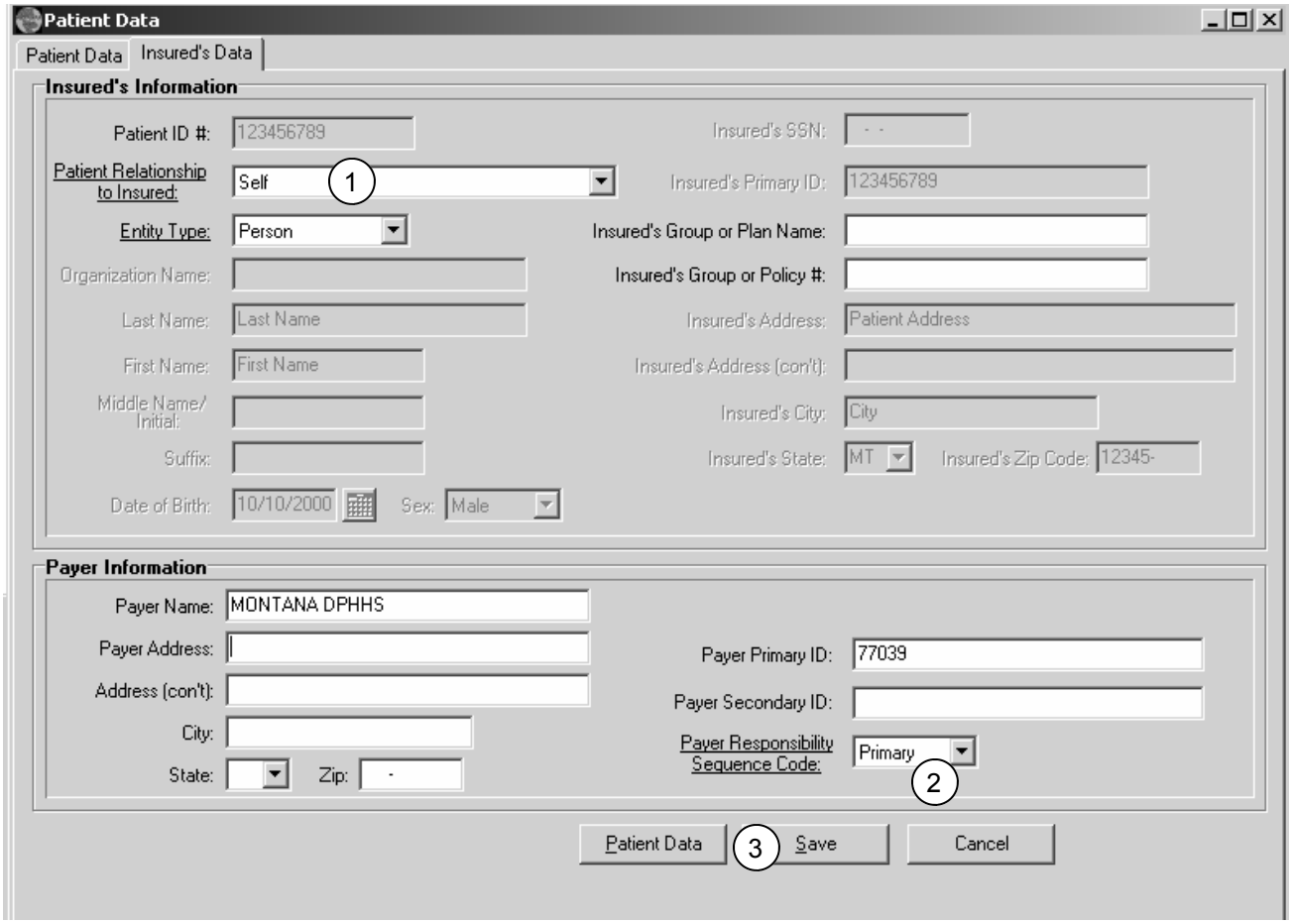
The provider will now appear on the Provider List. Add additional provider numbers using the same instructions.

Entering Patient Data



Under the Reference pull-down menu at top of screen, select “Patient.” This will open the Patient List. Click on “Add” to add a patient to the list.

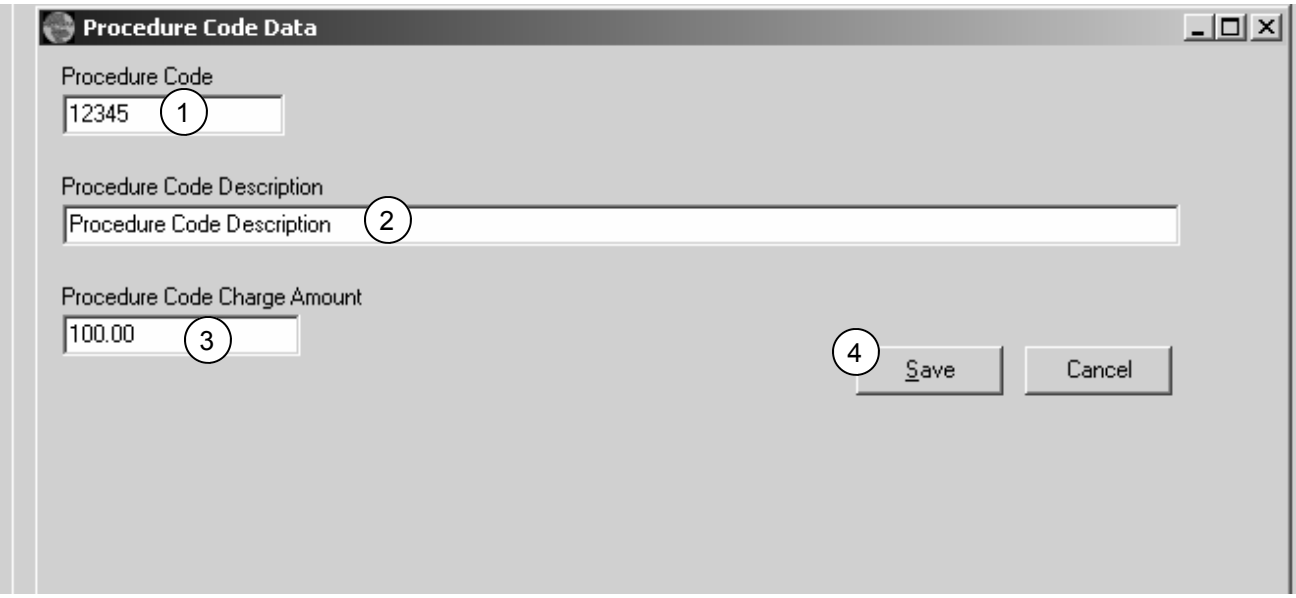
1. Enter the Client ID number. This is a nine-digit number, usually the client’s social security number.
2. Enter the Patient Account number. If you do not assign patient account numbers, enter the Client ID number. ***Do not leave blank.***
3. Enter patient’s last name, first name in appropriate fields. (Middle name/suffix is optional.)
4. Enter patient’s date of birth (mm/dd/ccyy)
5. On the pull-down menu, select patient sex indicator.
6. Enter patient’s address, including city, state, & zip code. (Telephone number is not required.)
7. Click on “Insurance” to go to second screen.



1. On the pull-down menu, select “Self.” This will automatically populate the appropriate fields in the upper section of the screen. DPHHS clients are always “Self.”
2. On the pull-down menu, indicate whether Medicaid is primary, secondary, or tertiary.
3. Click on “Save.”

The patient will now appear on the Patient List. Add additional patients using the same instructions.

Entering Procedure, Diagnosis, & Revenue Codes



Note: Unlike provider and patient data, procedure codes, diagnosis codes, and revenue codes do not have to be entered into the reference databases prior to incorporating them into a claim. These codes can be entered directly into the claim entry screen.

Under the Reference pull-down menu at top of screen, select “Procedure Code.” This will open the Procedure Code List. Click on “Add” to add a procedure code to the list.

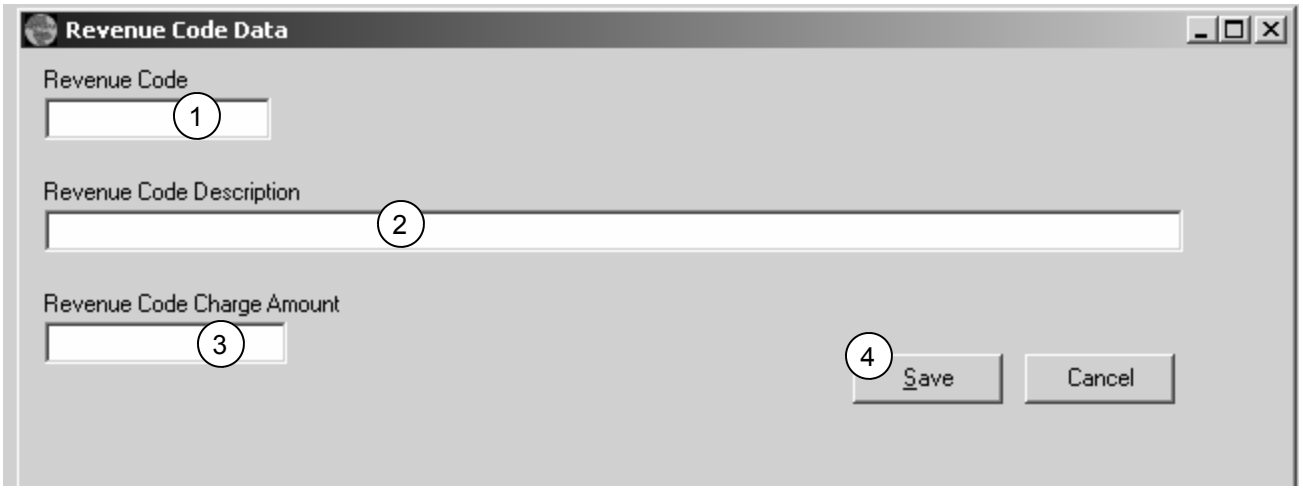
1. Enter the HCPCS code. (Note: Do not add code modifiers here.)
2. Enter a description of the procedure/service.
3. Enter the charge amount. (If the charge is variable, do not enter the charge amount. Charges can be entered manually in the claim entry screen.)
4. Click on “Save.”

The procedure code will now appear on the Procedure List. Add additional procedure codes using the same instructions.

Under the Reference pull-down menu at top of screen, select “Diagnosis.” This will open the Diagnosis Code List. Click on “Add” to add a diagnosis code to the list.

1. Enter the diagnosis code. Note: you will not see the decimal, but it is recognized to follow after the third digit, i.e., 12310 = 123.10.
2. Enter a description of the diagnosis.
3. Click on “Save.”

The diagnosis code will now appear on the Diagnosis Code List. Add additional diagnosis codes using the same instructions.

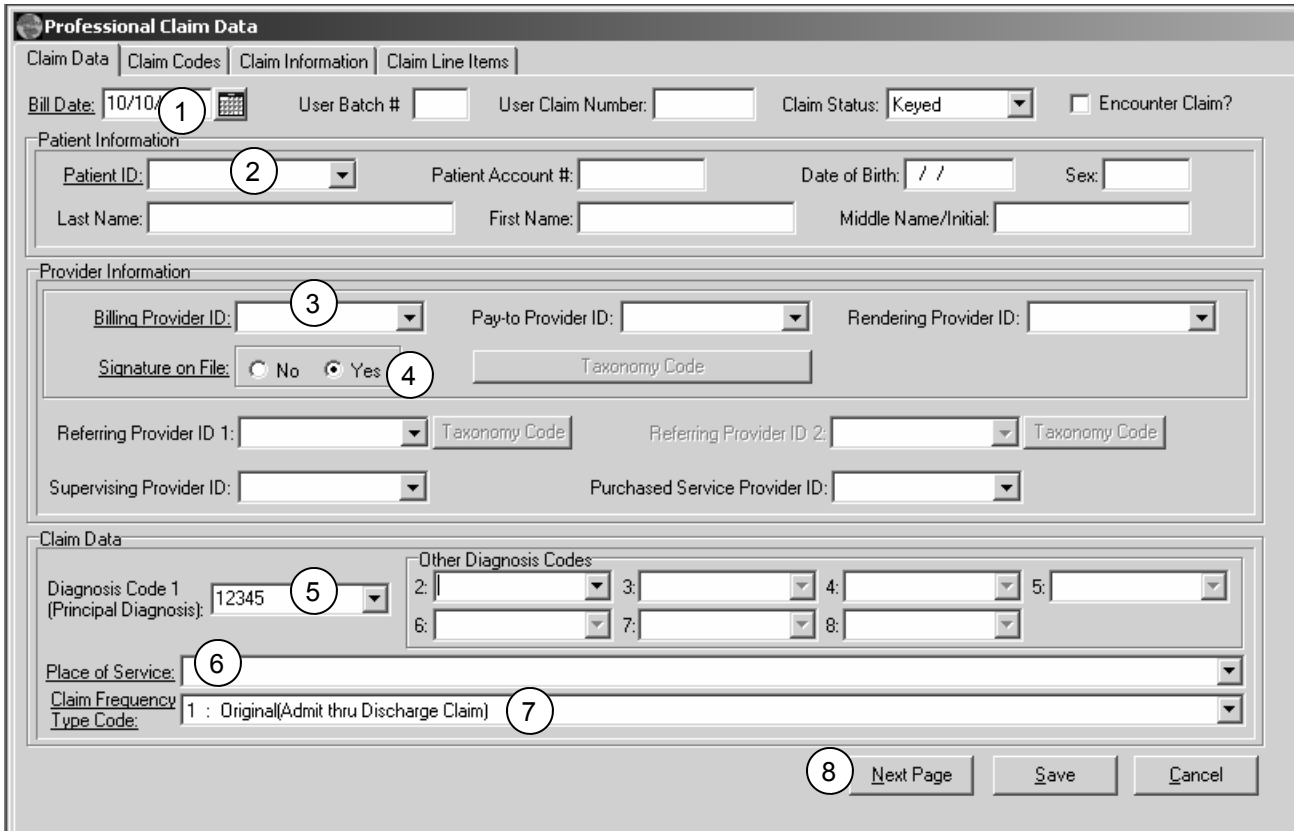


Under the Reference pull-down menu at top of screen, select “Revenue Code.” This will open the Revenue Code List. Click on “Add” to add a revenue code to the list.

1. Enter the revenue code.
2. Enter a description of the revenue code.
3. Enter the charge amount. (If the charge is variable, do not enter the charge amount. Charges can be entered manually in the claim entry screen.)
4. Click on “Save.”

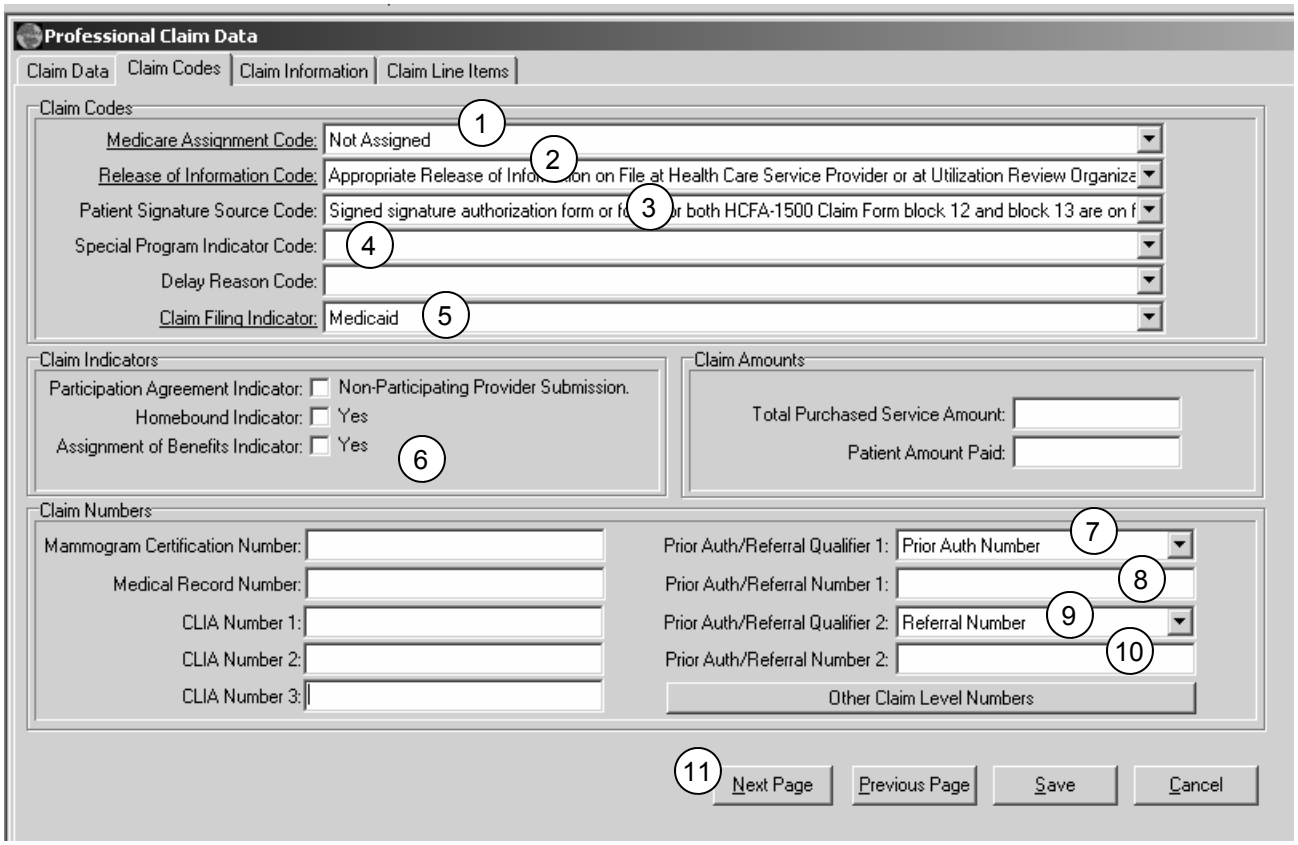
The revenue code will now appear on the Revenue Code List. Add additional revenue codes using the same instructions.

Building a Professional Claim (CMS-1500 format)



Under the Claims pull-down menu at top of screen, select “Professional.” This will open the Professional Claim List. Click on “Add” to add a professional claim to the list.

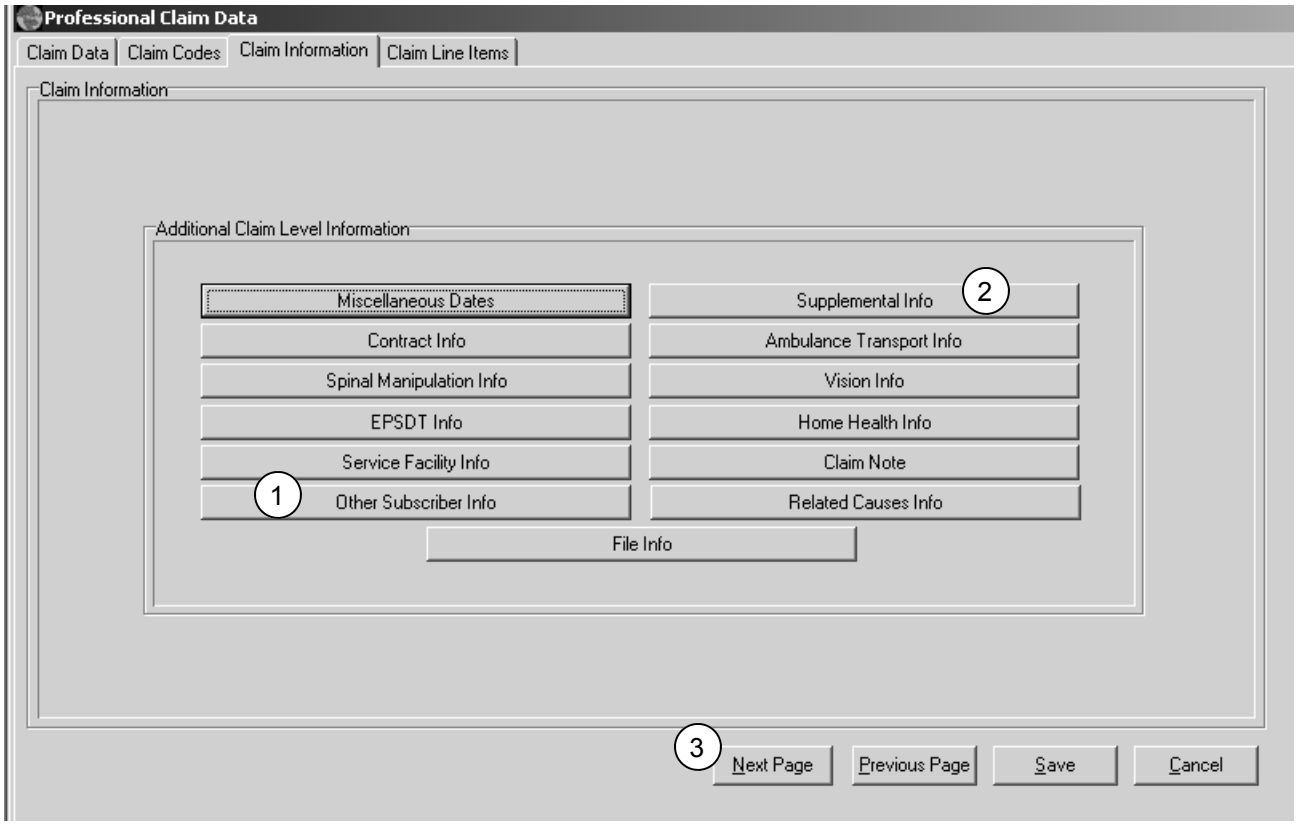
1. Enter the bill date (mm/dd/ccyy). (Press F5 key to enter current date.)
2. Use the pull-down menu to access the Patient List, select patient ID number.
3. Use the pull-down menu to access the Provider List, select the billing provider ID number.
4. Indicate “Yes,” Signature on File.
5. Enter the diagnosis code. Either key in the diagnosis code or access the Diagnosis Code List using the pull-down menu. For diagnosis codes with fourth or fifth digits, the decimal point will not be visible, but WINASAP will recognize that it lies between the third and fourth digits. Enter additional diagnosis codes in the Other Diagnosis Codes fields.
6. Under the pull-down menu, select the Place of Service.
7. Under the pull-down menu, always select “1: Original (Admit thru Discharge Claim).”
8. Click on “Next Page.”



1. If known, select the appropriate Medicare Assignment Code from the pull-down menu. If not known, select "Not Assigned"—this is the recommended default. (This is a HIPAA-required field.)
2. Under the pull-down menu, select the entry that best reflects your office protocol regarding release of information. (This is a HIPAA-required field.)
3. Under the pull-down menu, select the entry that best reflects your office protocol regarding patient signature consenting to release of information. (This is a HIPAA-required field.)
4. (Optional.) To indicate EPSDT at the claim level, select "EPSDT" on the pull-down menu.
5. Under the pull-down menu, <u>always</u> select "Medicaid."
6. A situational field will appear here if patient is female, check "yes" box to indicate pregnancy. Note: When the "yes" box is checked, a situational window will appear to enter "Last Menstrual Period." Enter any non-future date to close this window.
7. If the claim requires a prior authorization number, select "Prior Auth Number" under the pull-down menu.
8. Enter the prior authorization number.
9. If the claim requires a PASSPORT number, select "Referral Number" under the pull-down menu.
10. Enter the PASSPORT number.

    Note: The PA number and/or PASSPORT number can be entered in either the top fields (1) or bottom fields (2).

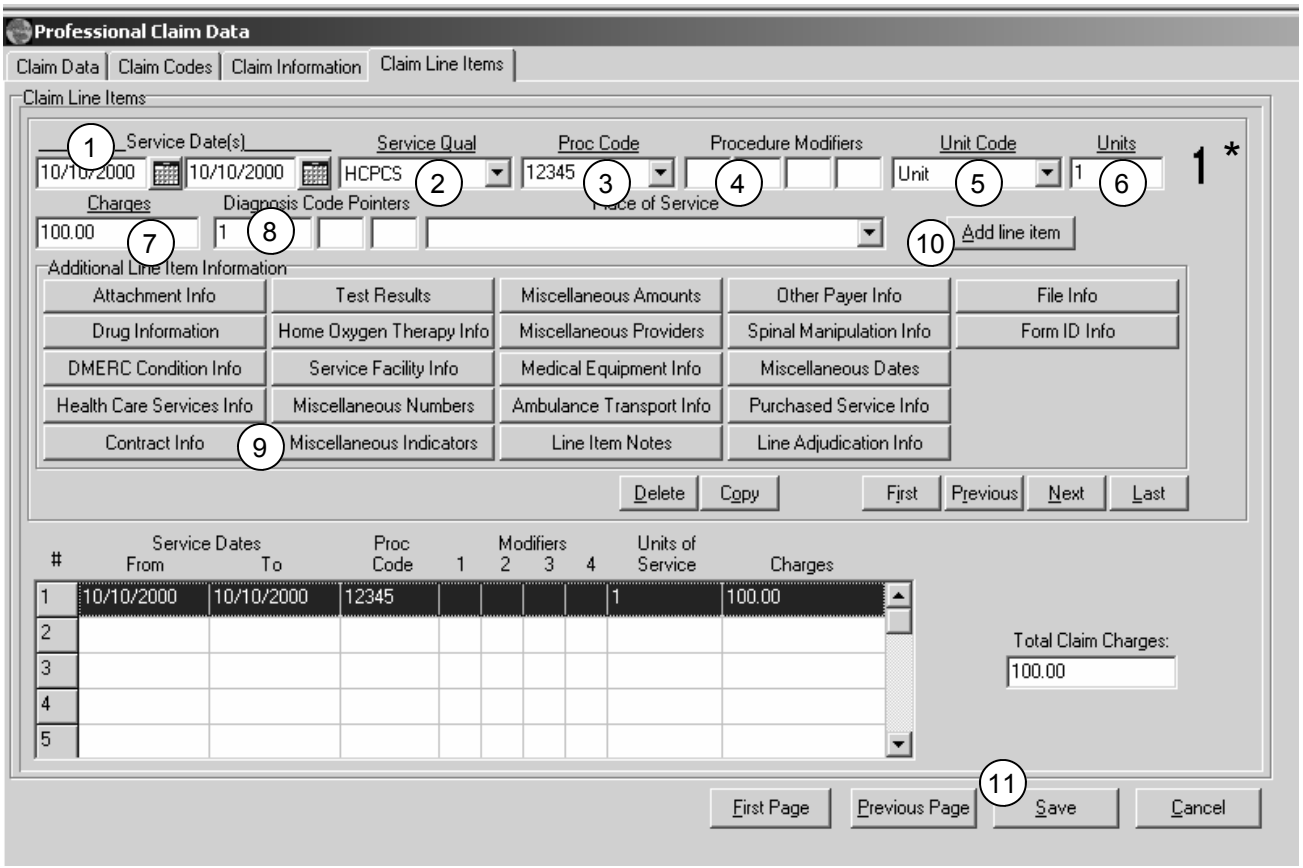
11. Click on "Next Page."



In most cases, there are no required fields on this screen. However, there are two fields that may be required for your claim. “Other Subscriber Info” can be entered if the patient has another insurance (TPL) that pays primary to Medicaid. “Supplemental Info” can be used to indicate that a paperwork attachment to the electronic claim has been sent by mail, or to reference a blanket denial letter on file in the ACS TPL Unit.

Specialized instructions for these fields can be found in Appendices A & B.

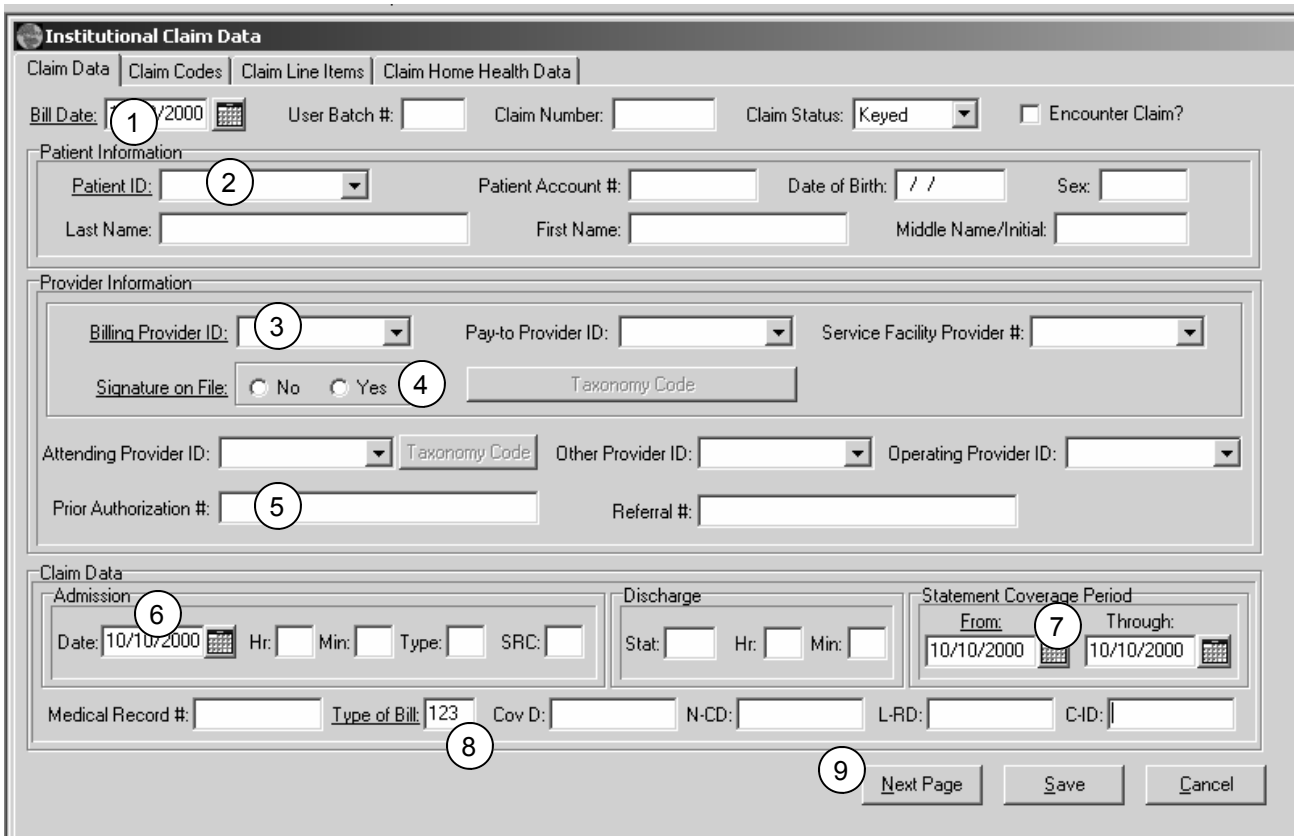
1. To enter TPL information, click on “Other Subscriber Info”
2. To enter paperwork attachment information, click on “Supplemental Info.”
3. Click on “Next Page.”



* The number in the upper right corner of this screen indicates which line is being entered. As each line is added, this number will change to indicate which line is being entered. The total claim charges will appear in the box on the lower left. WINASAP can accommodate up to 39 line items in a single claim.

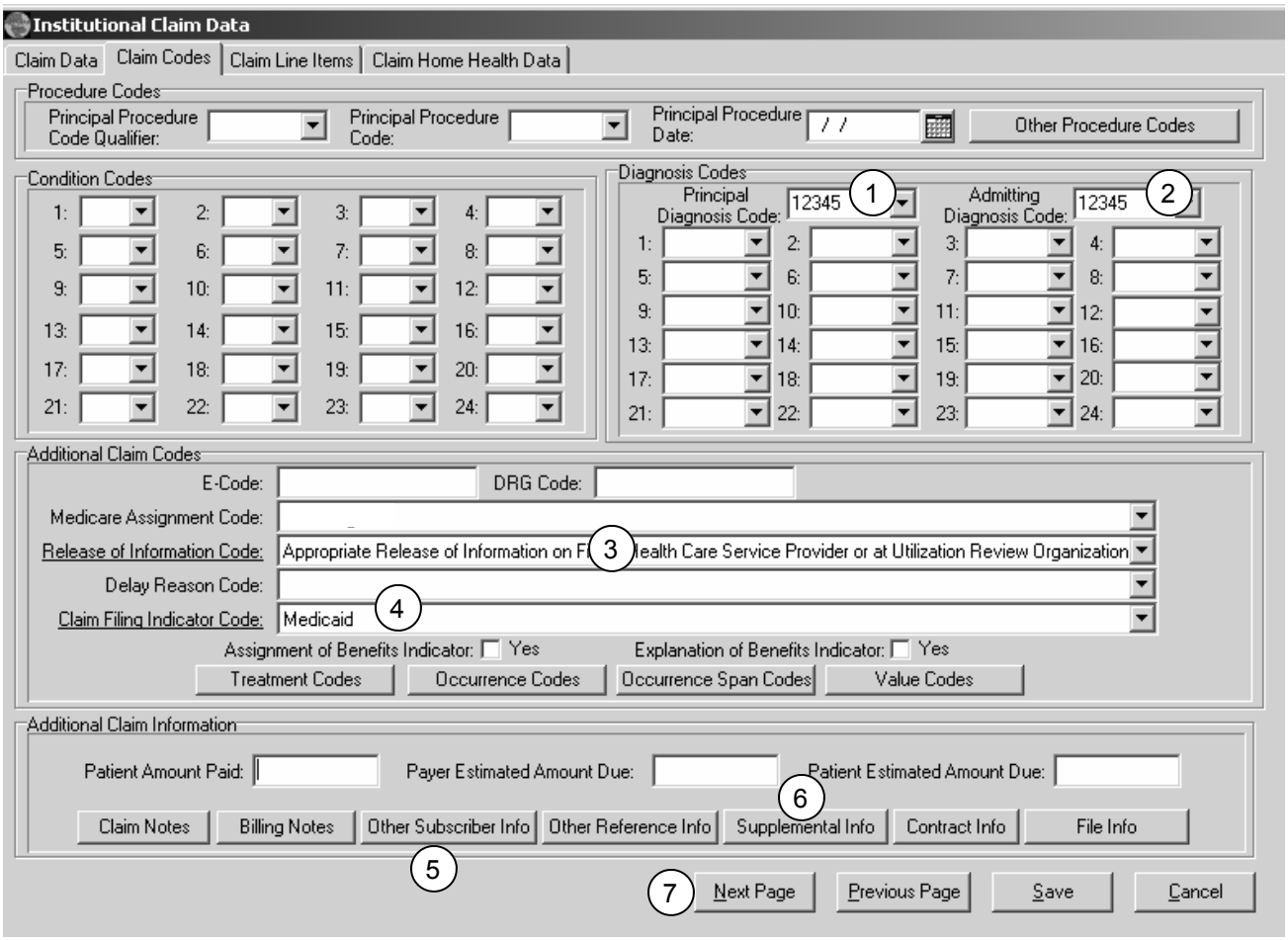
1. Enter the date(s) of service (mm/dd/ccyy). If a single date of service, enter the date in both fields.
2. Under the pull-down menu, always select “HCPCS.”
3. Enter the HCPCS procedure/service code. Either key in the code or access the Procedure Code List using the pull-down menu.
4. Enter any or up to four procedure code modifiers.
5. Under the pull-down menu, always select “Unit.”
6. Enter the number of units being billed.
7. Enter the charges. Note: If the procedure code was previously entered into the reference database with the corresponding per unit charge, WINASAP will automatically calculate the charge.
8. Enter the diagnosis code pointer(s).
9. To indicate EPSDT, Family Planning, or both, click on “Misc Indicators.” Under “Other Indicators,” check “yes” under “Was the service the result of a screening referral?” To indicate family planning, check “yes” under family planning. For both, check each box “yes.” (Pregnancy indicator is located on Claim Codes screen under Claim Indicators.)
10. Click on “Add line item.” Repeat steps above to add additional lines.
11. When all line items have been entered, click on “Save.”

Building an Institutional Claim (UB-92 Format)

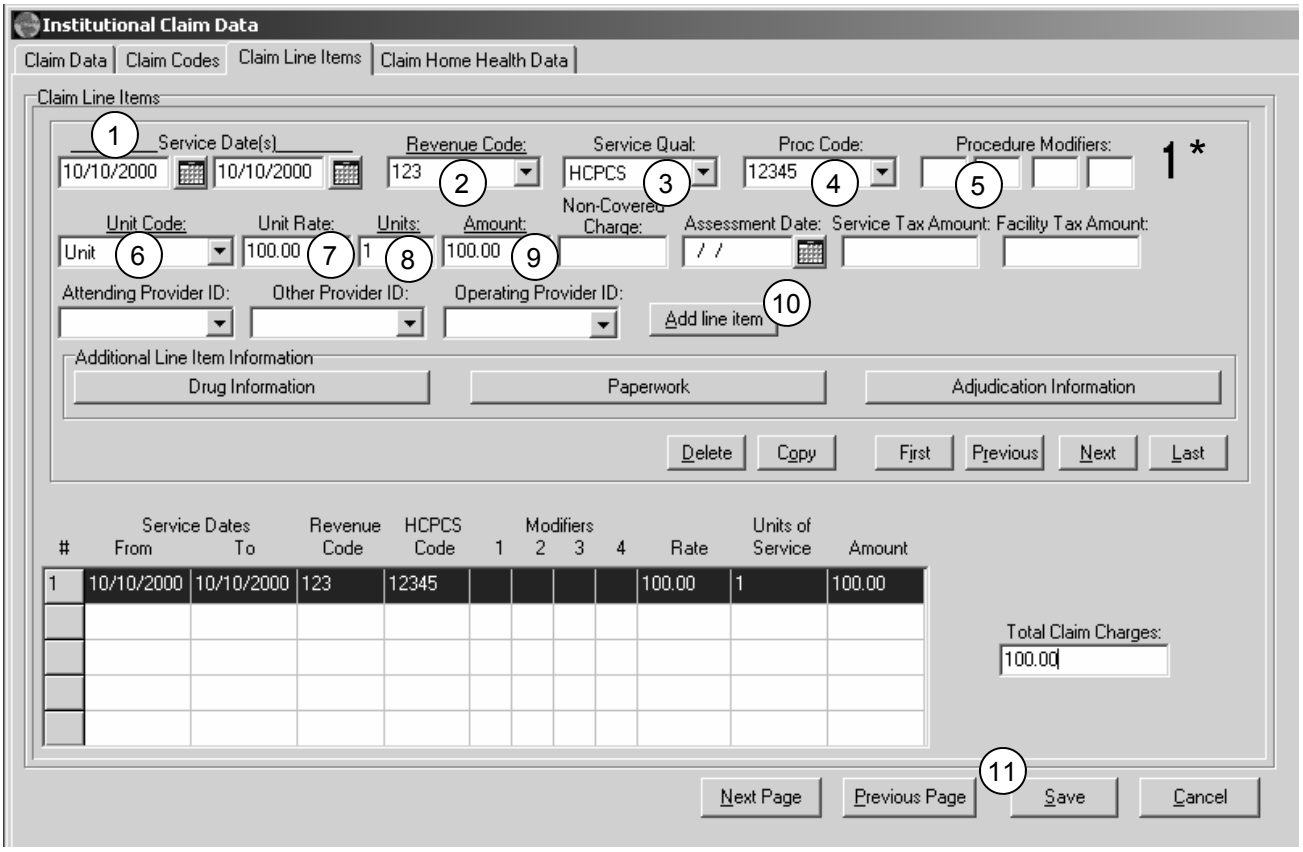


Under the Claims pull-down menu at top of screen, select “Institutional.” This will open the Institutional Claim List. Click on “Add” to add an institutional claim to the list.

1. Enter the bill date (mm/dd/ccyy). (Press F5 key to enter current date.)
2. Use the pull-down menu to access the Patient List, select patient ID number.
3. Use the pull-down menu to access the Provider List, select the billing provider ID number.
4. Indicate “Yes,” Signature on File.
5. If required, enter the prior authorization number.
6. Enter the admission date (mm/dd/ccyy).
7. Enter the statement coverage period dates (mm/dd/ccyy).
8. Enter the type of bill.
9. Click on “Next Page.”



1. Enter the principal diagnosis code. Either key in the diagnosis code or access the Diagnosis Code List using the pull-down menu. For diagnosis codes with fourth or fifth digits, the decimal point will not be visible, but WINASAP will recognize that it lies between the third and fourth digits.
2. Enter the admitting diagnosis code. Either key in the diagnosis code or access the Diagnosis Code List using the pull-down menu. For diagnosis codes with fourth or fifth digits, the decimal point will not be visible, but WINASAP will recognize that it lies between the third and fourth digits. Enter additional diagnosis codes in the Other Diagnosis Codes fields.
3. Under the pull-down menu, select the entry that best reflects your office protocol regarding release of information. (This is a HIPAA-required field.)
4. Under the pull-down menu, always select "Medicaid."
5. If there is TPL that pays primary to Medicaid, click on "Other Subscriber Info" to enter the TPL information. (See Appendix A.)
6. Click on "Supplemental Info" to indicate that a paperwork attachment to the electronic claim has been sent by mail, or to reference a blanket denial letter on file in the ACS TPL Unit. (See Appendix B.)
7. Click on "Next Page."

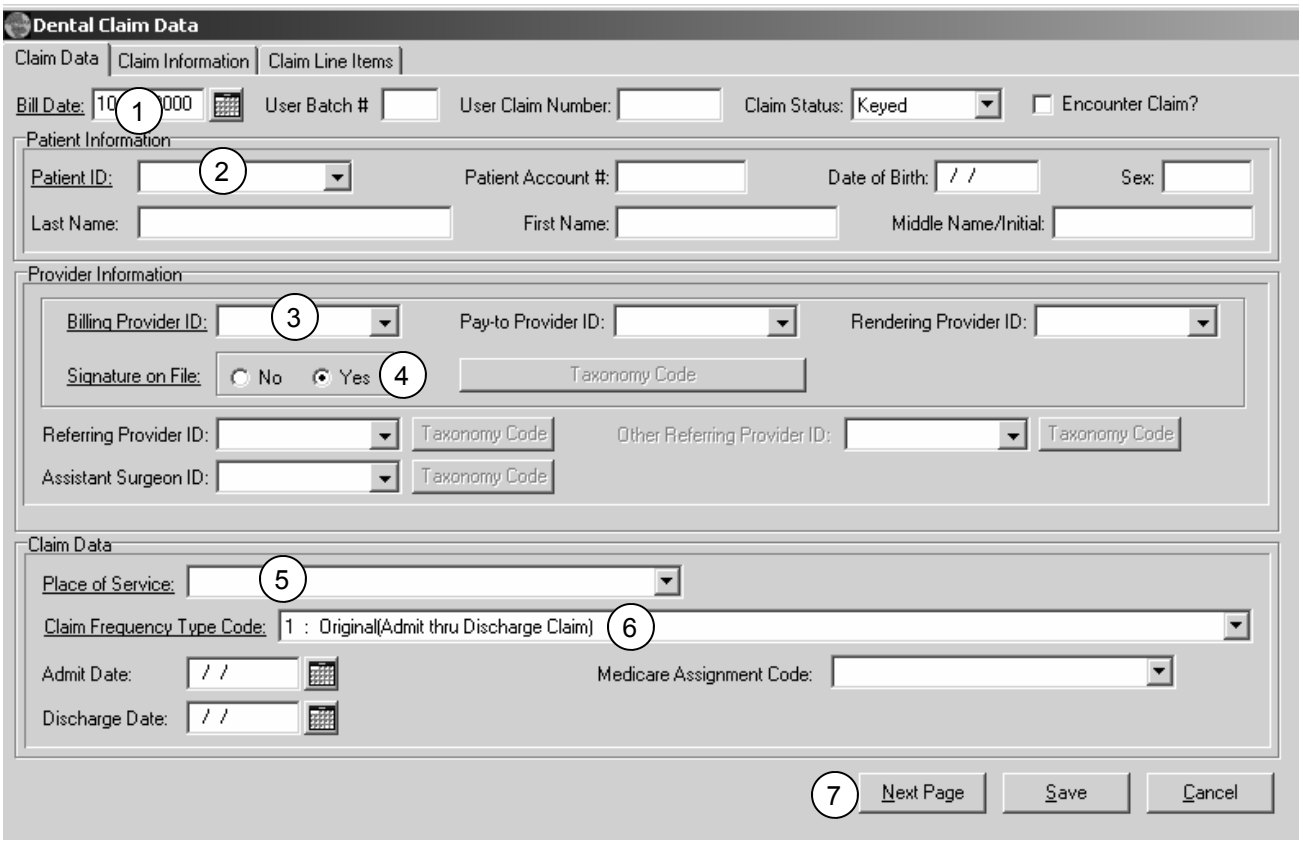


* The number in the upper right corner of this screen indicates which line is being entered. As each line is added, this number will change to indicate which line is being entered. The total claim charges will appear in the box on the lower left. WINASAP can accommodate up to 39 line items in a single claim.

1. Enter the date(s) of service (mm/dd/ccyy). If a single date of service, enter the same date in both fields.
2. Enter the revenue code. Either key in the code or access the Revenue Code List using the pull-down menu.
3. If entering a HCPCS procedure code on the line, under the pull-down menu, select “HCPCS.” (Note: Leave this field blank if there is no HCPCS code entered in field 4.)
4. Enter the HCPCS procedure/service code. Either key in the code or access the Procedure Code List using the pull-down menu.
5. Enter any or up to four procedure code modifiers.
6. Under the pull-down menu, always select “Unit.”
7. Enter the unit rate.
8. Enter the number of units being billed.
9. Enter the charges. Note: If the procedure code and/or revenue code was previously entered into the reference database with the corresponding per unit charge, WINASAP will automatically enter the charge. If there is both a revenue code and procedure code entered, WINASAP will use the revenue code to calculate the charge.
10. Click on “Add Line Item.” Repeat steps above to add additional line charges.
11. When all line items have been entered, click on “Save.”

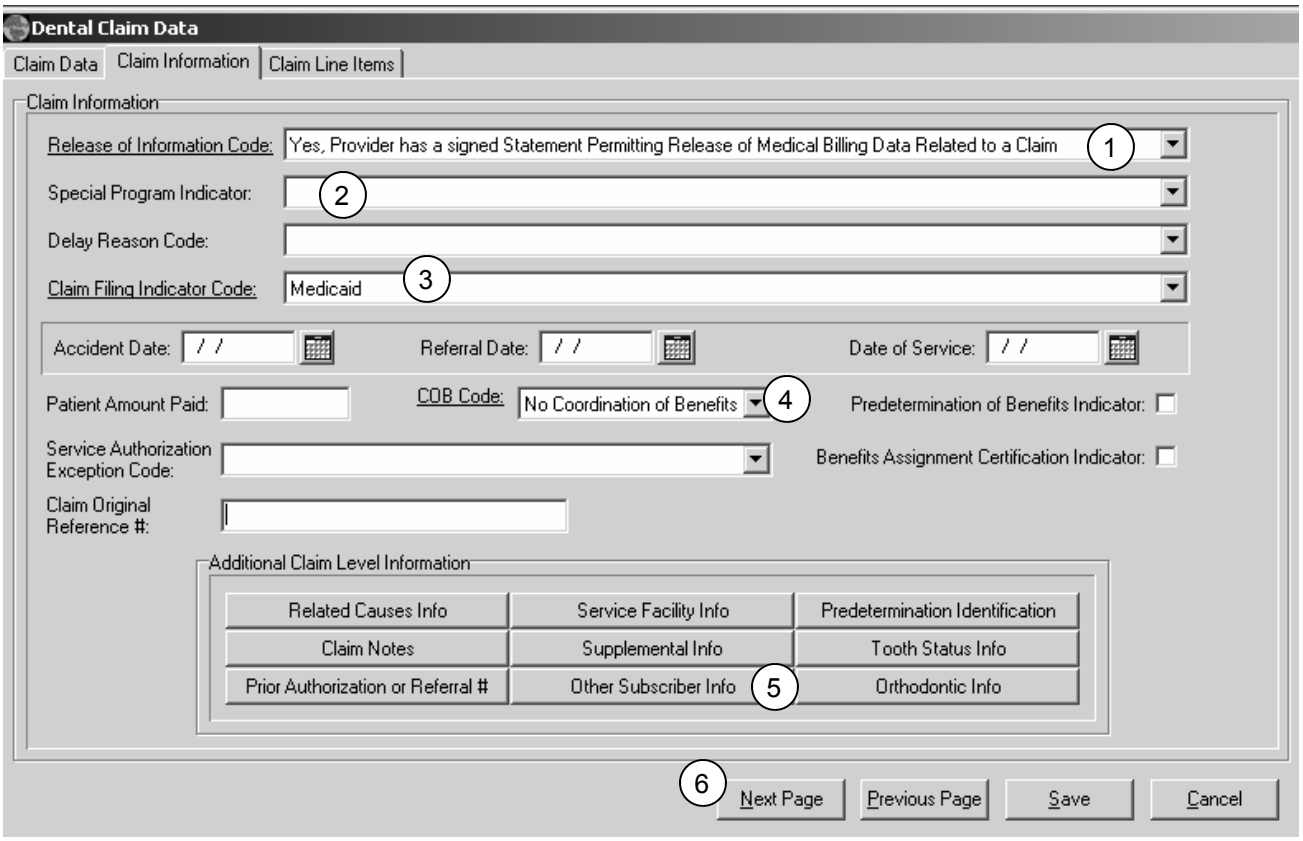
The claim will now appear on the Institutional Claim List. Add additional claims using the same instructions.

Building a Dental Claim

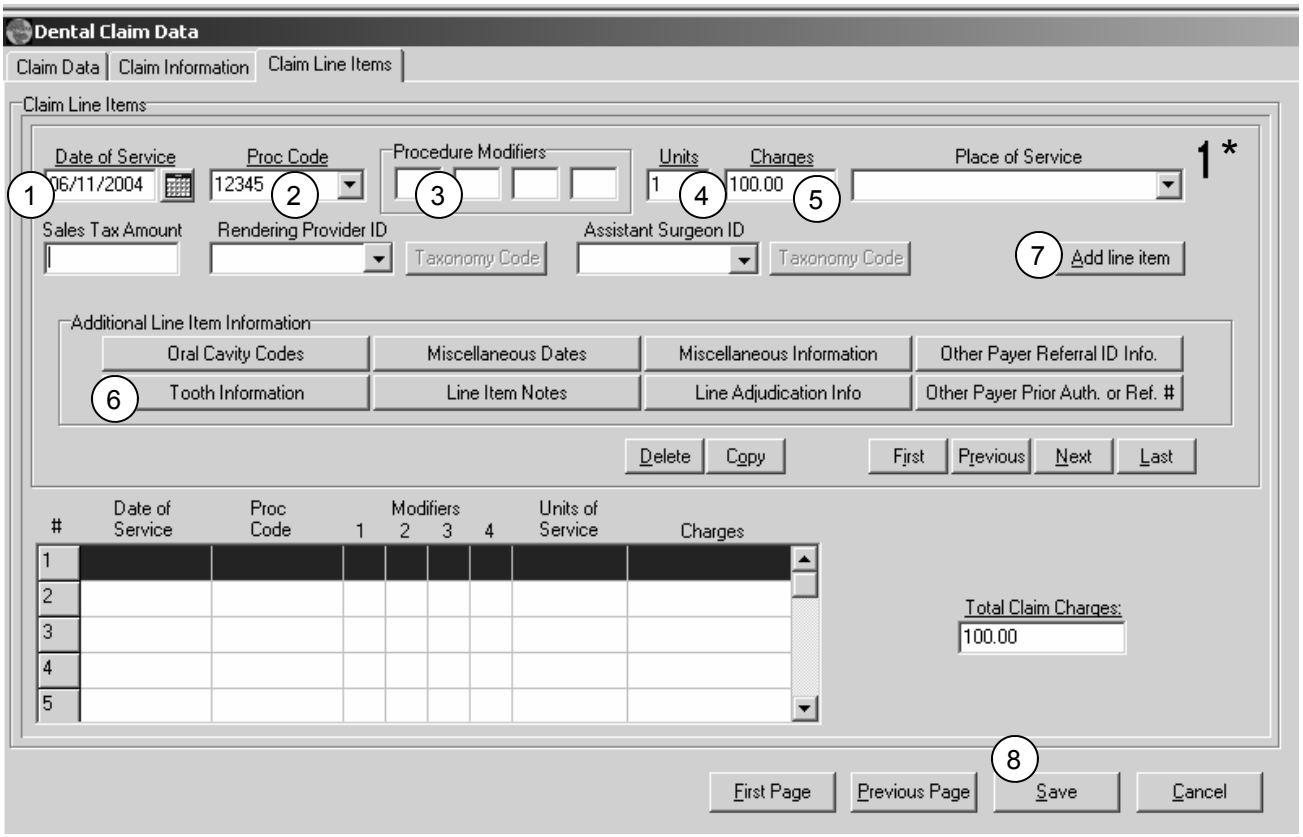


Under the Claims pull-down menu at top of screen, select “Dental.” This will open the Dental Claim List. Click on “Add” to add a dental claim to the list.

1. Enter the bill date (mm/dd/ccyy). (Press F5 key to enter current date.)
2. Use the pull-down menu to access the Patient List, select patient ID number.
3. Use the pull-down menu to access the Provider List, select the billing provider ID number.
4. Indicate “Yes,” Signature on File.
5. Under the pull-down menu, select the Place of Service.
6. Under the pull-down menu, always select “1: Original (Admit thru Discharge Claim).”
7. Click on “Next Page.”



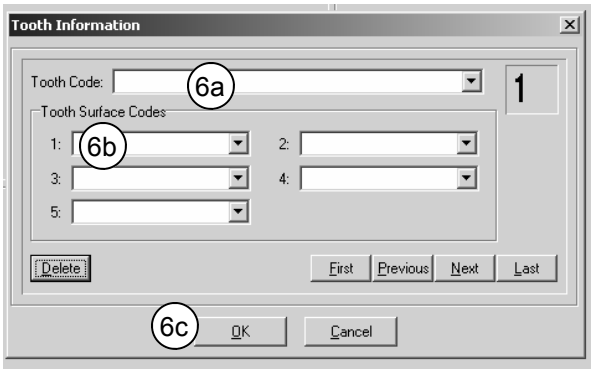
1. Under the pull-down menu, select the entry that best reflects your office protocol regarding release of information. (This is a HIPAA-required field.)
2. (Optional.) To indicate EPSDT at the claim level, select “EPSDT” on the pull-down menu.
3. Under the pull-down menu, always select “Medicaid.”
4. Under the pull-down menu, enter COB or no COB.
5. If COB, click on “Other Subscriber Info” and follow instructions in Appendix A.
6. Click on “Next Page.”



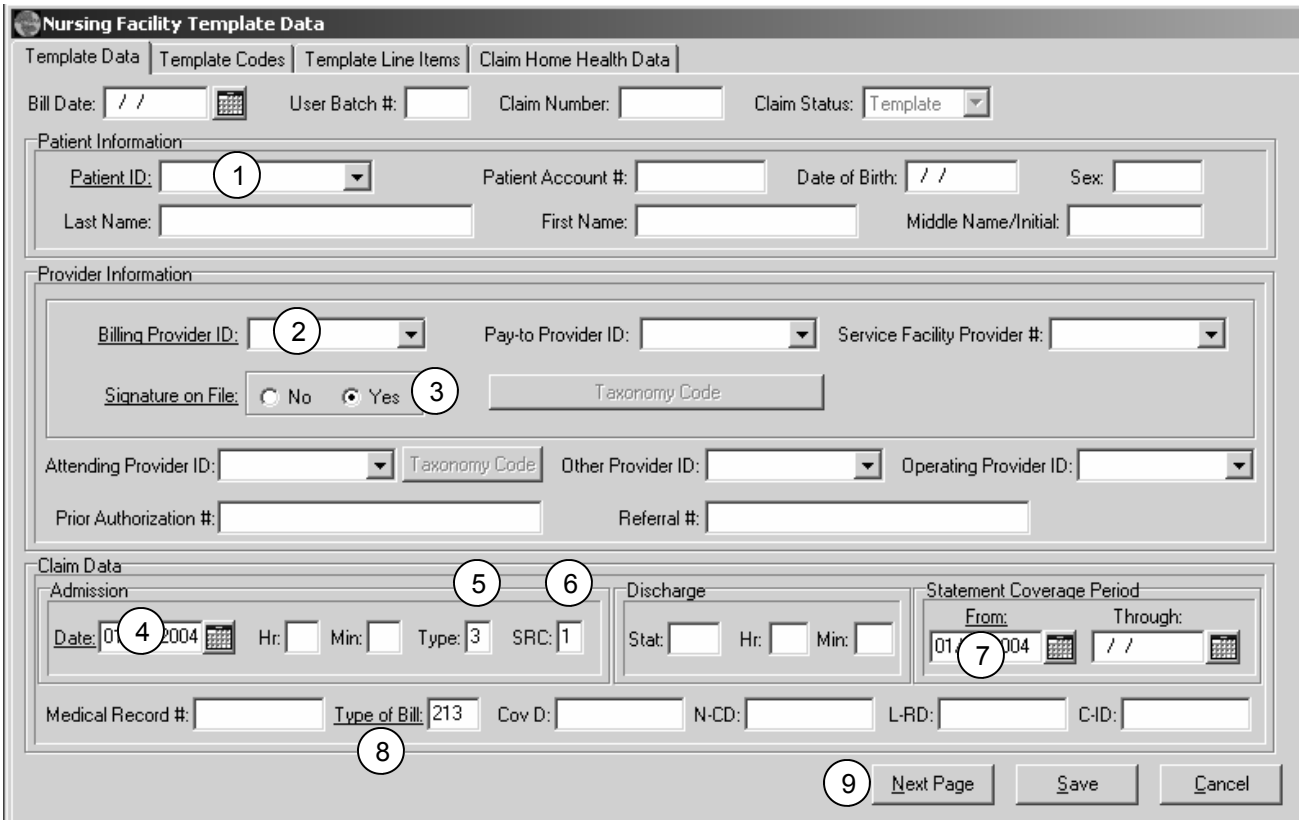
* The number in the upper right corner of this screen indicates which line is being entered. As each line is added, this number will change to indicate which line is being entered. The total claim charges will appear in the box on the lower left. WINASAP can accommodate up to 39 line items in a single claim.

1. Enter the date of service (mm/dd/ccyy).
2. Enter the CDT procedure/service code. Either key in the code or access the Procedure Code List using the pull-down menu.
3. Enter any or up to four procedure code modifiers.
4. Enter the number of units being billed.
5. Enter the charges. Note: If the procedure code was previously entered into the reference database with the corresponding per unit charge, WINASAP will automatically enter the charge.
6. If applicable, click on “Tooth Information” to enter the tooth information related to the line charge.
   6a. Under the pull-down menu, select tooth code.
   6b. Under the pull-down menu(s), select the tooth surface codes.
   6c. When done, click “OK.”
7. Click on “Add line item.” Repeat steps above to add additional lines.
8. When all line items have been entered, click on “Save.”

The claim will now appear on the Dental Claim List. Add additional claims using the same instructions.



Building a Nursing Home Claim Template (UB-92 format)



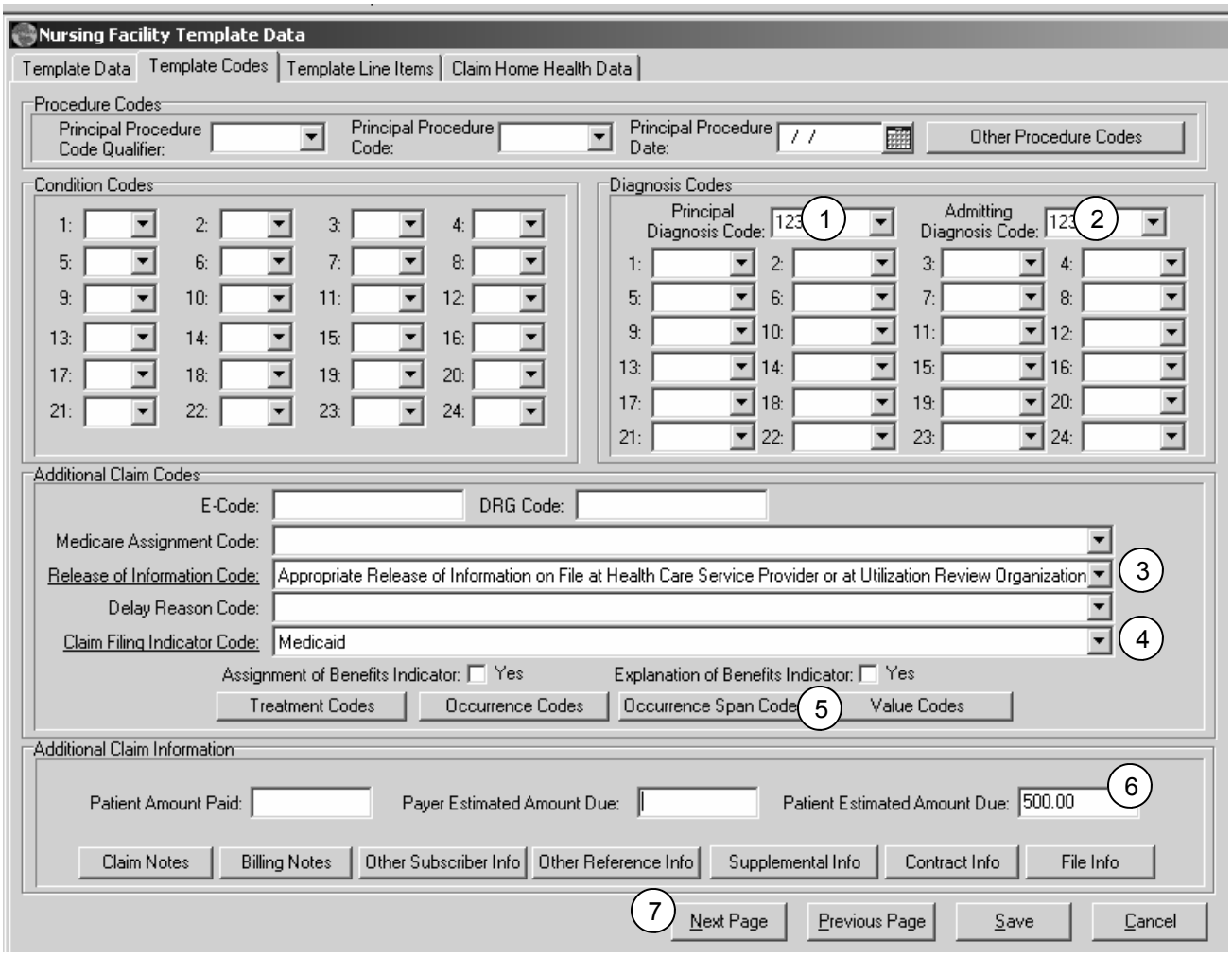
Nursing home claims utilize a template to facilitate ongoing monthly billing. Once a template is created for each resident, subsequent claims are created by entering the billing month. WINASAP will automatically generate a new claim for each resident.

Under the Claims pull-down menu at top of screen, select “Nursing Facility,” then “Nursing Facility Template.” This will open the Nursing Facility Template List. Click on “Add” to add a template to the list.

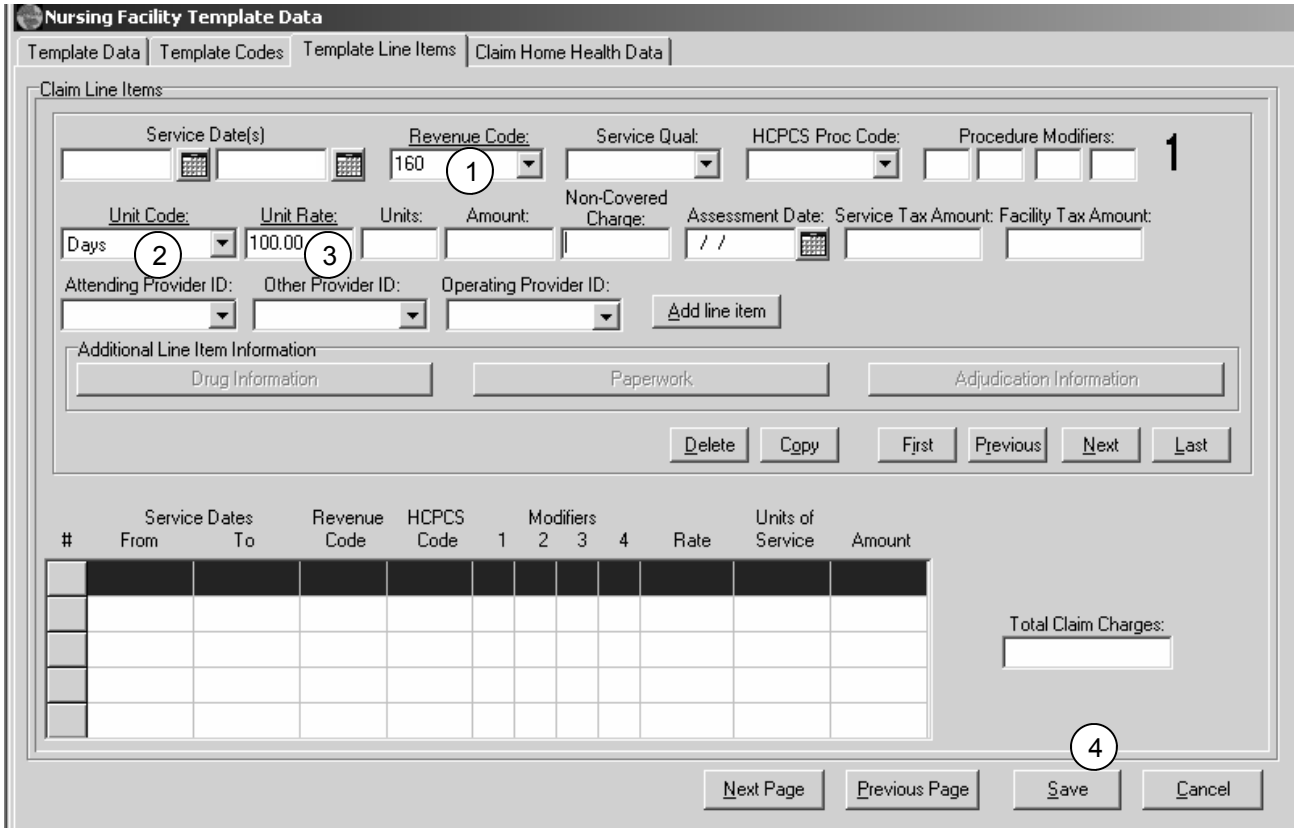
Note: Like all WINASAP electronic claims, patient and provider data must be entered prior to creating a template or claim.

Note: Since this a claim template, many of the date fields are left blank, but will be filled in automatically when building claims.

1. Select Patient ID from pull-down menu.
2. Select Provider ID from pull-down menu.
3. Indicate “yes” for signature on file.
4. Enter Admission Date (mm/dd/ccyy)
5. Enter Admission Type code (see UB Manual)
6. Enter Admission Source code (see UB Manual)
7. Enter Statement Coverage From Date (enter Admission Date mm/dd/ccyy)
8. Enter Type of Bill.
9. Click on “Next Page.”



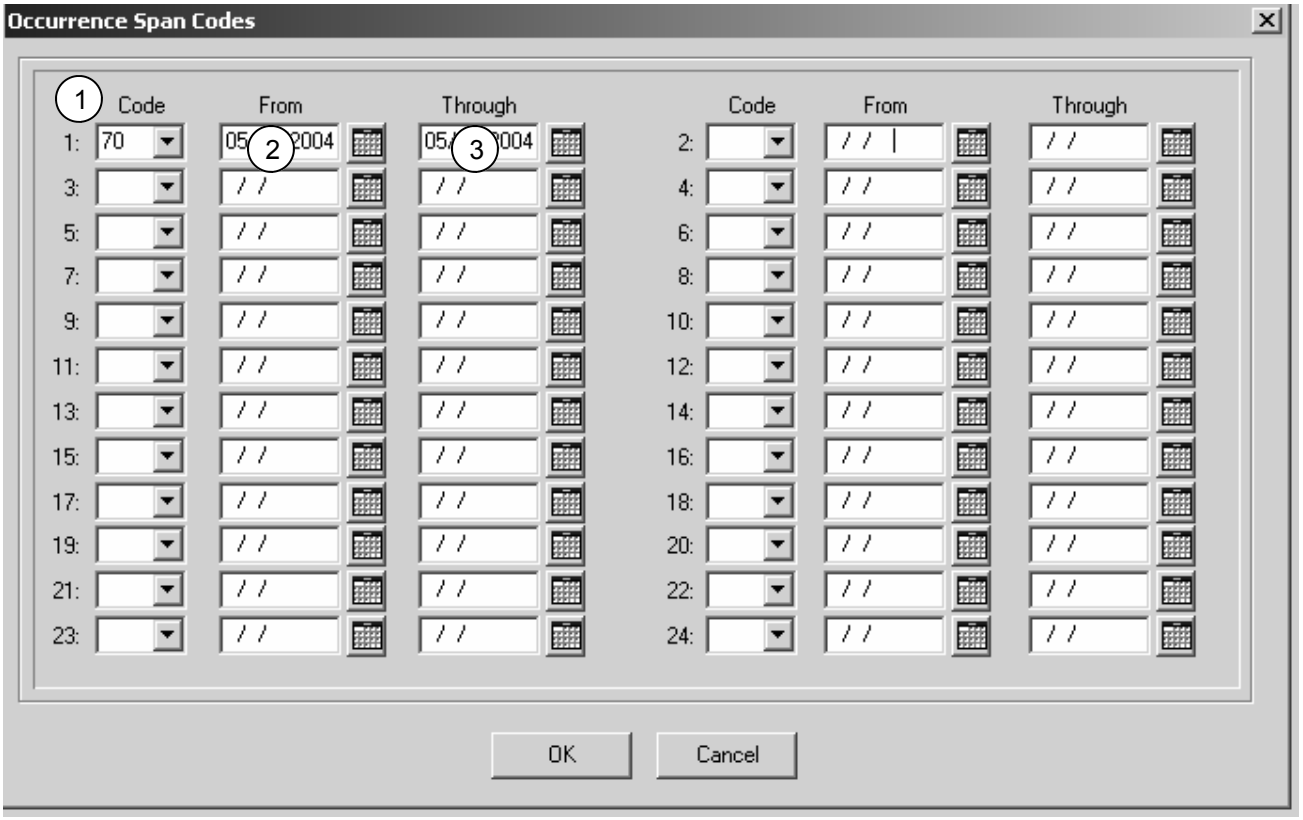
1. Enter Principal Diagnosis Code (Note: you will not see the decimal, but it is recognized to follow after the third digit, i.e., 12310 = 123.10.)
2. Enter Admitting Diagnosis Code (Note: you will not see the decimal, but it is recognized to follow after the third digit, i.e., 12310 = 123.10.)
3. Select Release of Information Code from pull-down menu.
4. Under Claim Filing Indicator, select “Medicaid” from pull-down menu.
5. Click on Occurrence Span Code button to change level of care from 2 (intermediate) to 1 (skilled) (see page 24).
6. Enter Personal Resources Amount in field labeled “Patient Estimated Amount Due.”
7. Click on “Next Page.”



1. Enter Revenue Code (160). Either key in the amount or access the Revenue Code List using the pull-down menu.
2. In the Unit Code field, select “Days” on the pull-down menu.
3. Enter the daily rate.
4. Click on “Save.”

Note: There are no required fields on the Claim Home Health Data screen.

The claim will now appear on the Nursing Facility Template List. Add additional templates using the same instructions.



To indicate level of care:

Level of Care 1 = skilled
Level of Care 2 = intermediate

Default is Level of Care 2. No action necessary.

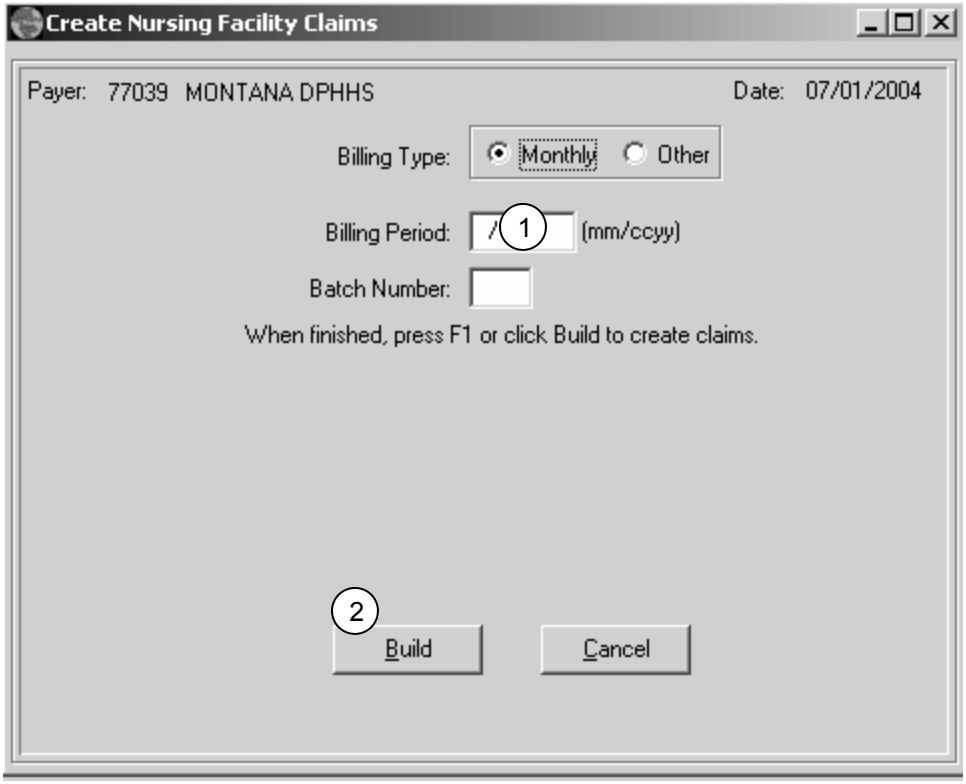
To indicate Level of Care 1:

Under Occurrence Span Codes screen:

1. Enter “70” in Code field.
2. Enter From Date (mm/dd/ccyy)
3. Enter Through Date (mm/dd/ccyy)
4. Click on “OK.”

Note: Level of Care does not affect reimbursement.

Building Nursing Home Claims From Template List



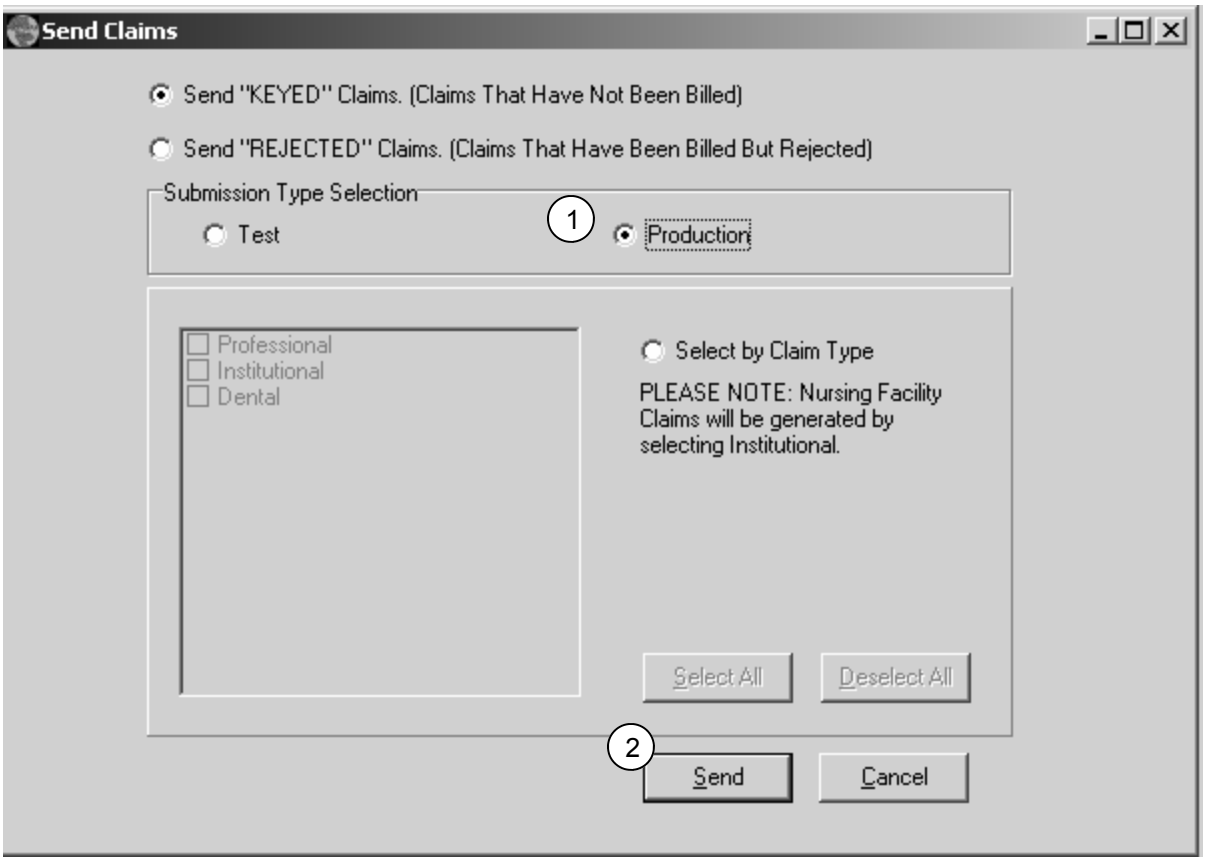
Under the “Tools” pull-down menu, select “Build Nursing Facility Claims.”

1. Enter month (mm/ccyy) in Billing Period field.
2. Click on “Build.”

WINASAP will generate a claim for each Nursing Facility template for the month entered.

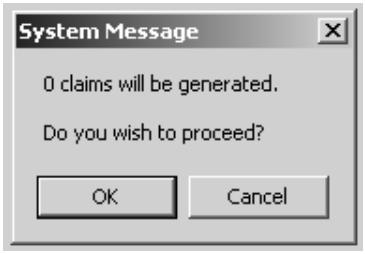
To make changes to claims, open the Nursing Facility Claims list under the Claims pull-down menu. Select the claim you wish to change, make any changes, then click on “Save.”

Submitting Claims



Under the Tools pull-down menu at the top of the screen, select “Send Claim File.” Note: All claim lists must be closed.

Default is to send “Keyed” (unbilled) claims.

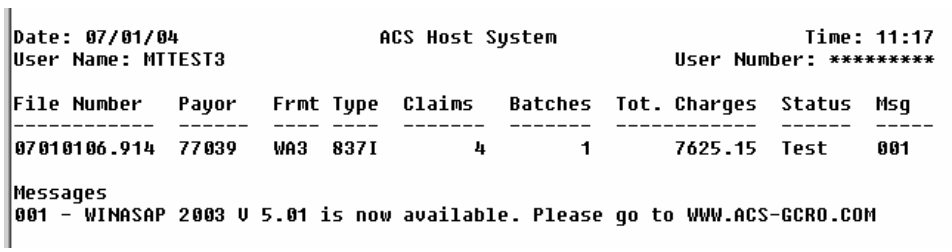


1. Click on “Production.” Every time this screen is pulled up hereafter, it will be set to production.
2. Click on “Send.”

Note: It is not necessary to select by claim type unless you wish to send different claim types in separate batches..

WINASAP will display a screen prompt “x number of claims will be generated. Do you wish to proceed?” Click “OK.”

Following transmission, you will receive a confirmation message.

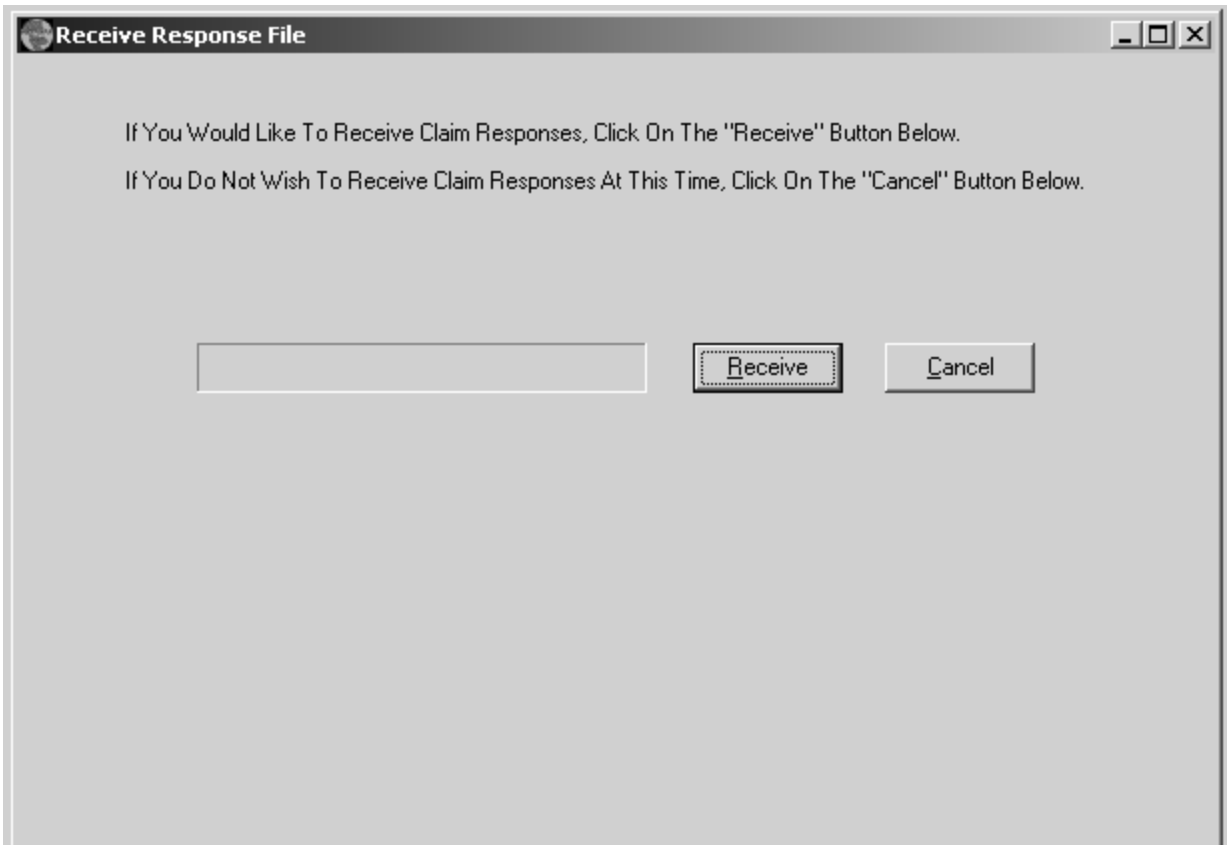


```
Date: 07/01/04                    ACS Host System                    Time: 11:17
User Name: MTTEST3                                          User Number: **********

File Number   Payor   Frmt Type  Claims   Batches  Tot. Charges  Status  Msg
-----------  ------  ---- ----  -------  -------  ------------  ------  -----
07010106.914  77039   WA3  837I        4        1       7625.15  Test    001

Messages
001 - WINASAP 2003 V 5.01 is now available. Please go to WWW.ACS-GCRO.COM
```

Receive Response File



Under the tools pull-down menu, select “Receive Response File.”

Click on “Receive.”

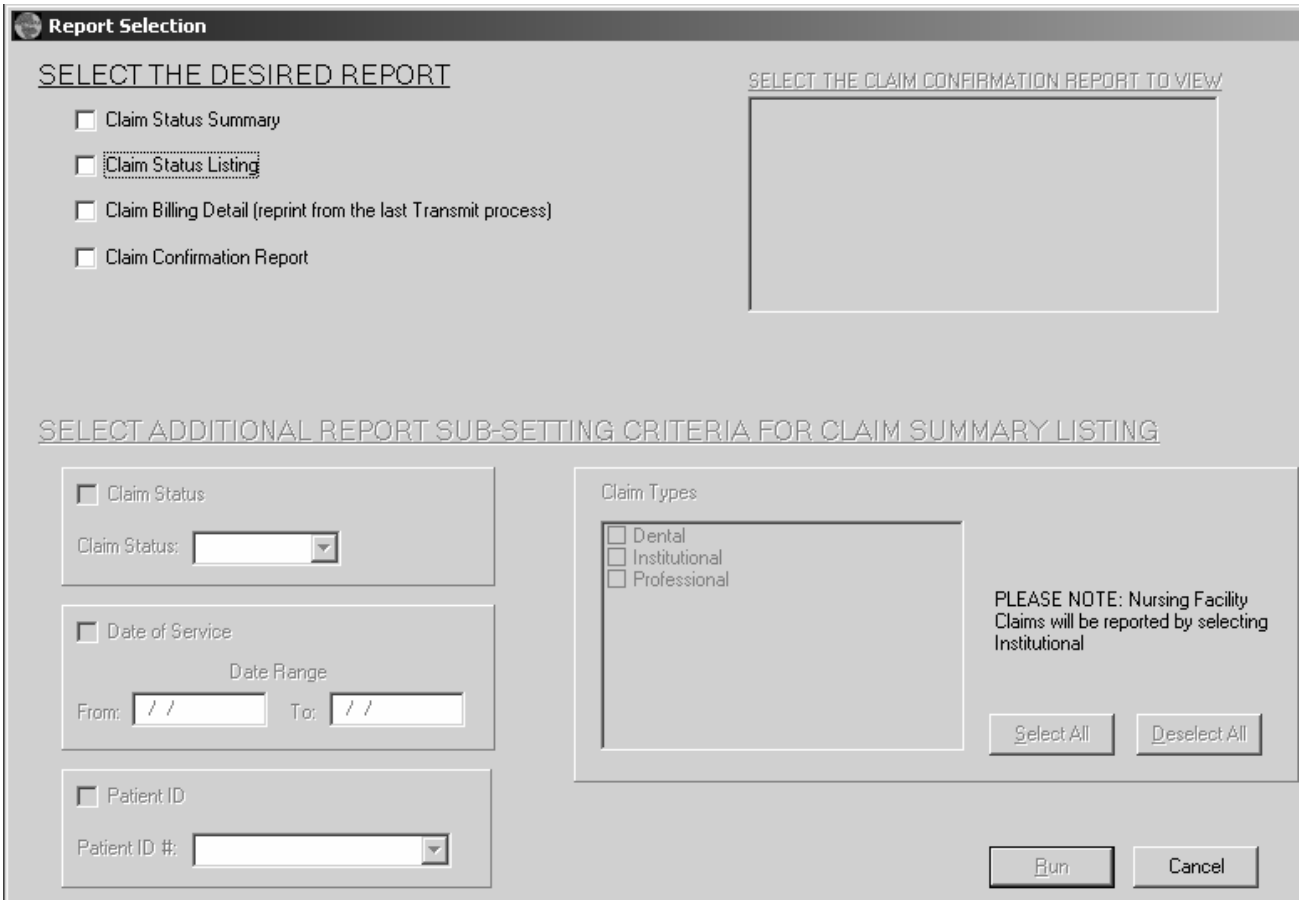
WINASAP will contact to the host and update the status or your sent claims on the claim list.

Unsent claims are in keyed status.

Sent claims are in billed status.

Following Receive Response File, sent claims will be either accepted or rejected. If a claim is marked as rejected, contact EDI Gateway at 1-800-987-6719 for an explanation and steps to correct.

Reports & Other Features



Under the tools pull-down menu, select “Reports.”

WINASAP can generate a variety of reports. Select the report type and criteria and click on “Run” in the lower right portion of the screen.

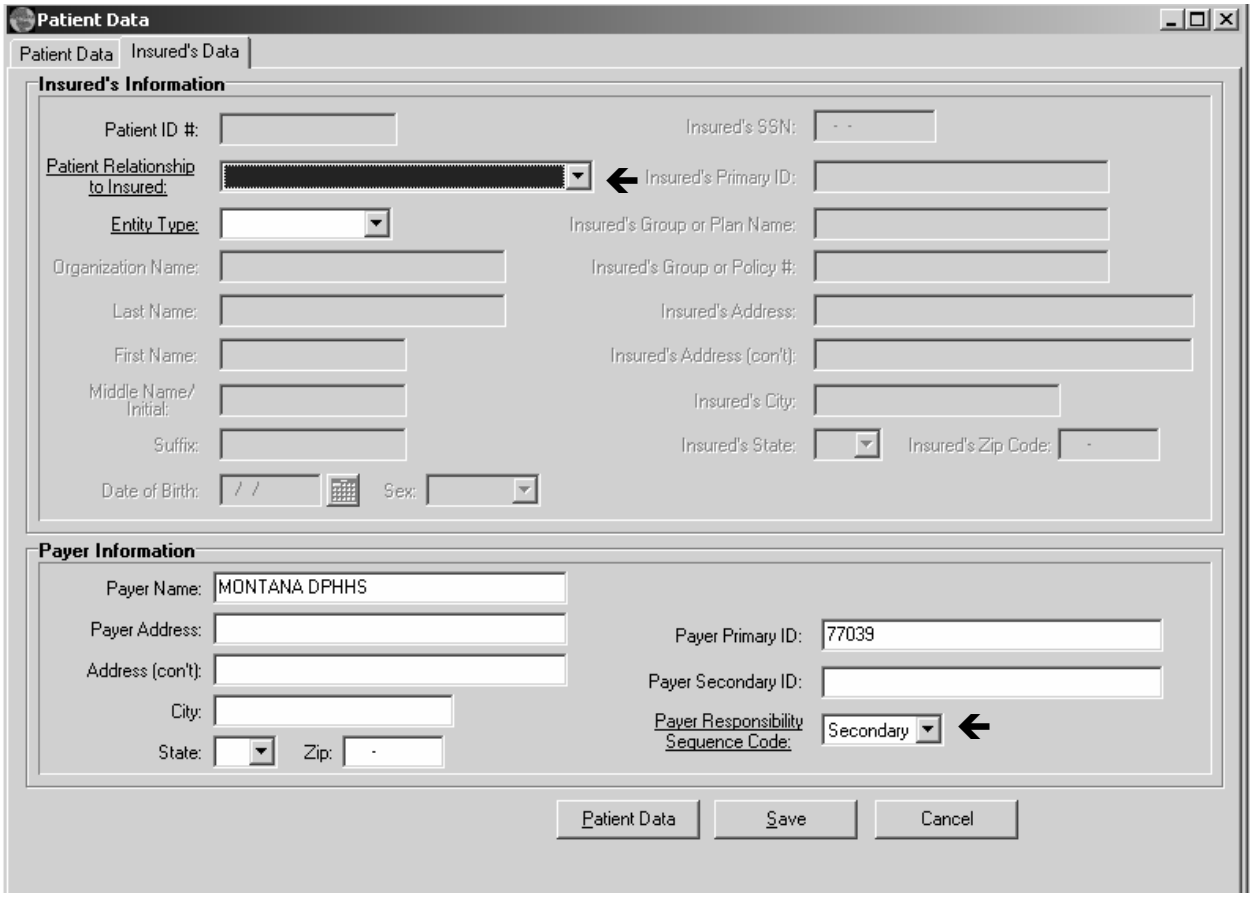
Other items of interest under the “Tools” menu:

- Back-up and restore database functions to protect your databases.
- Security settings to change passwords and add new users.
- Purge Claims function to archive old claims.

Appendices

Appendix A

Indicating TPL payments in a WINASAP Claim



For WINASAP professional claims where Medicaid pays secondary or tertiary to another insurer (TPL), providers should follow these instructions to enter the TPL paid amount and other TPL information.

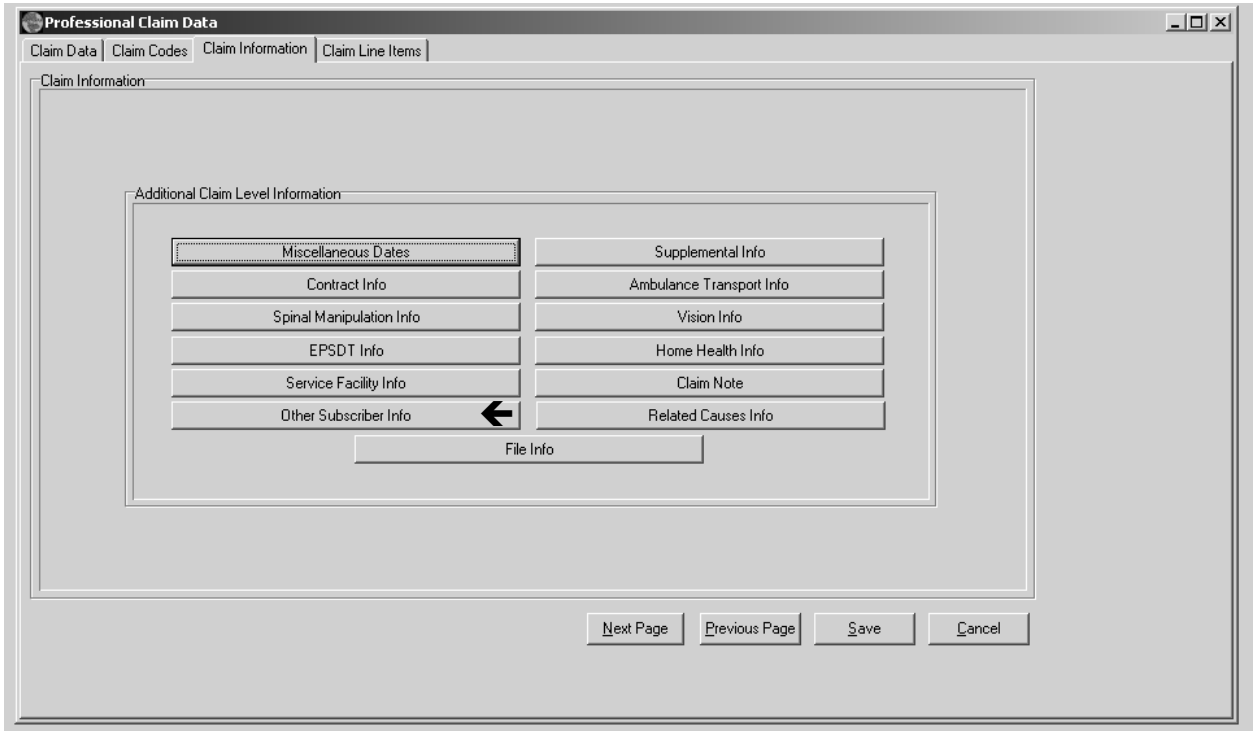
Note: Claims indicating a TPL payment (not including Medicare) do not require any attached paper documentation. However, an attachment is required if the TPL denies payment for non-covered services or exceeded benefits, etc.

The black arrows on the screen images indicate required fields.

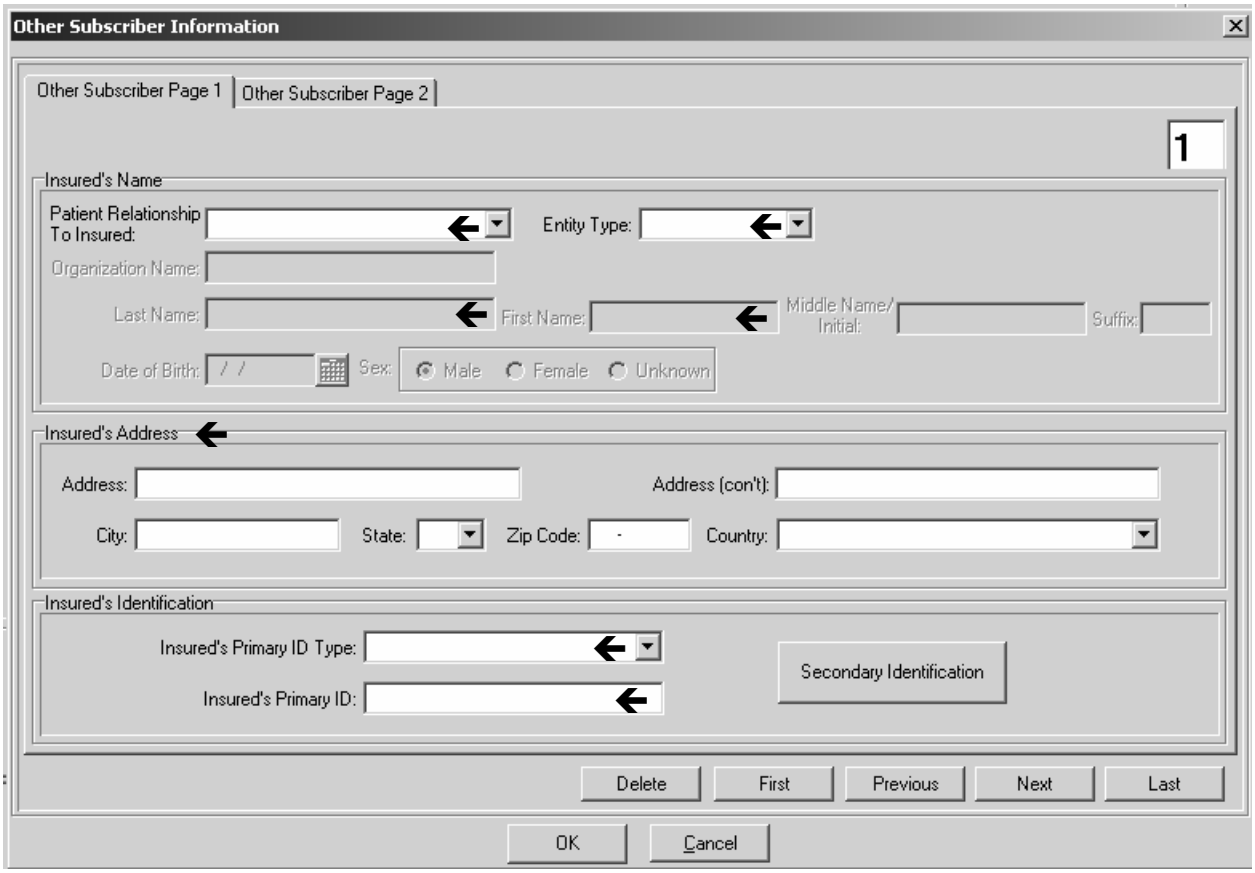
➔ In the patient reference database, on the second screen, under Patient Relationship To Insured, make sure “Self” is entered.

➔ Under Payer Responsibility Sequence Code, select Medicaid as “secondary” (or “tertiary,” if applicable).

➔ Hit “Save” to exit screen.



➔ On the third screen of the professional claim, Claim Information, click on “Other Subscriber Info.”

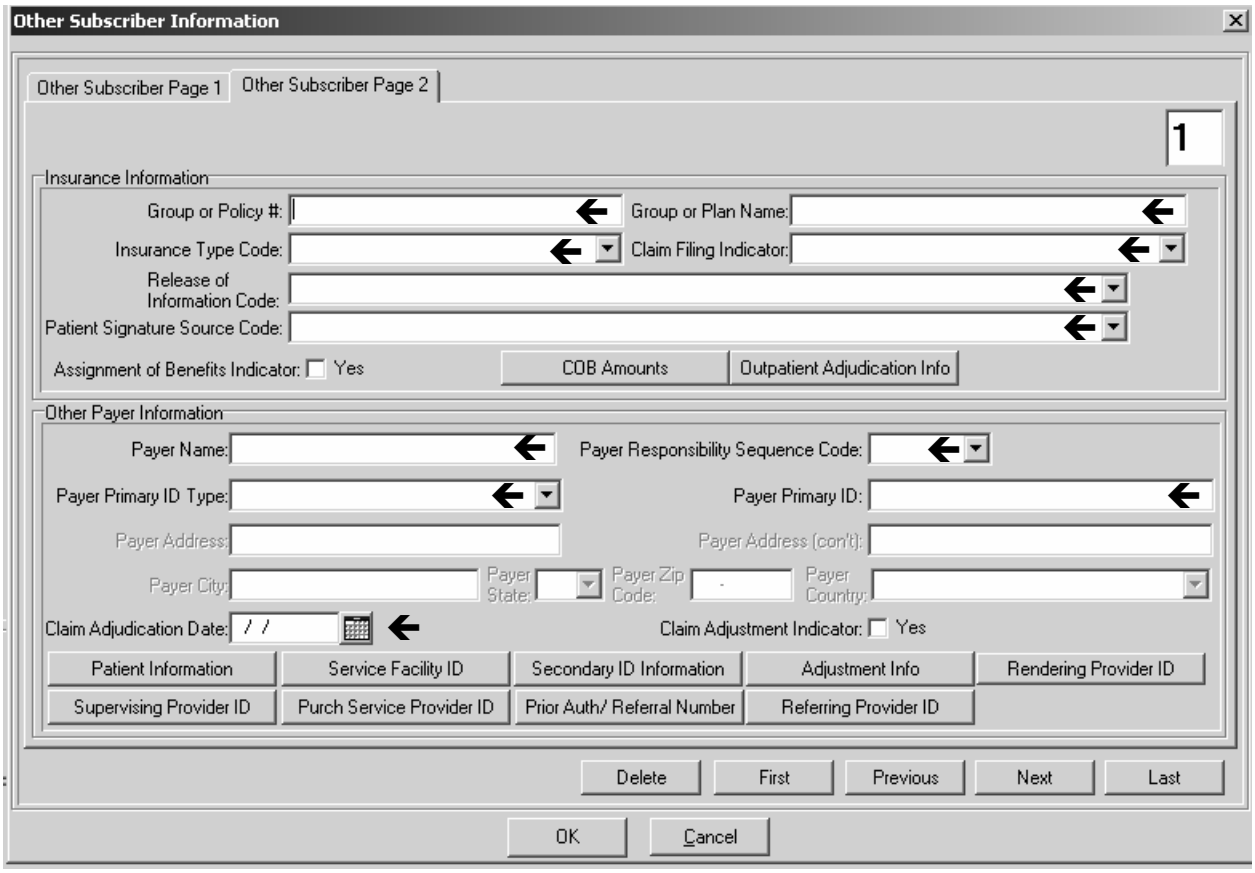


➔ Complete the following fields on page 1 of this screen.

- ➔ Patient Relationship To Insured
- ➔ Entity Type
- ➔ Last Name, First Name, Date of Birth, Gender of Insured
- ➔ Insured's Primary ID Type
- ➔ Insured's Primary ID

➔ Click on "OK" or the "Other Subscriber Page 2" tab at top to move to second page.

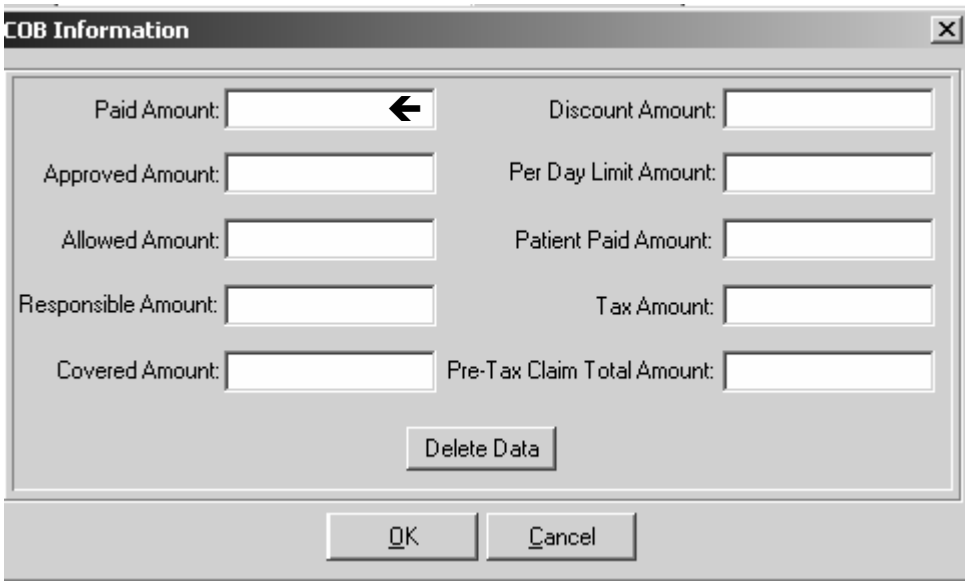
* The fields under Secondary Identification are not required.



➔ Complete the following fields on page 2 of this screen.

- ➔ Group or Policy #
- ➔ Group or Plan Name
- ➔ Insurance Type Code
- ➔ Claim Filing Indicator
- ➔ Release of Information Code
- ➔ Patient Signature Source Code
- ➔ Payer Name
- ➔ Payer Responsibility Sequence Code (enter “Primary”)
- ➔ Payer Primary ID Type
- ➔ Payer Primary ID
- ➔ Claim Adjudication Date

➔ Click on “COB Amounts.”



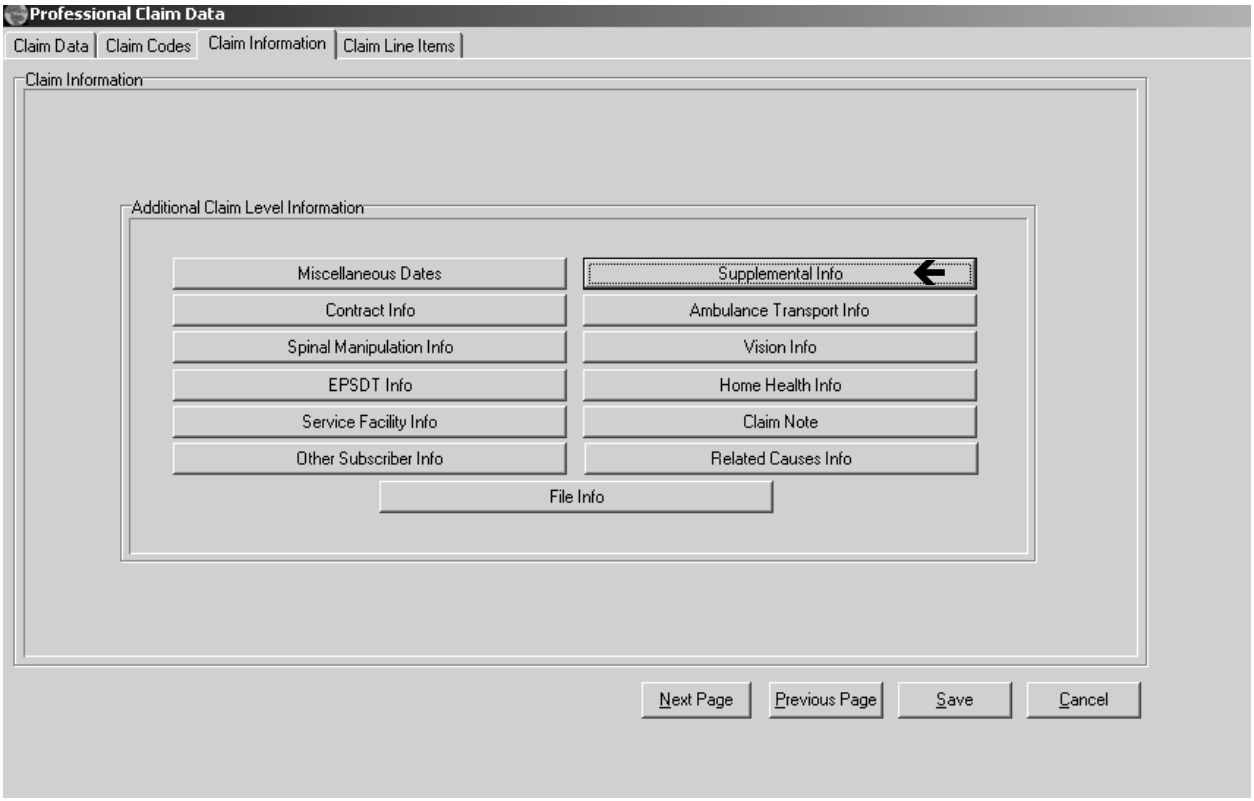
➔ Enter the “Paid Amount.” (TPL payment)

➔ Click on “OK.”

➔ Repeat the process for any other TPL payment on the claim.

Appendix B

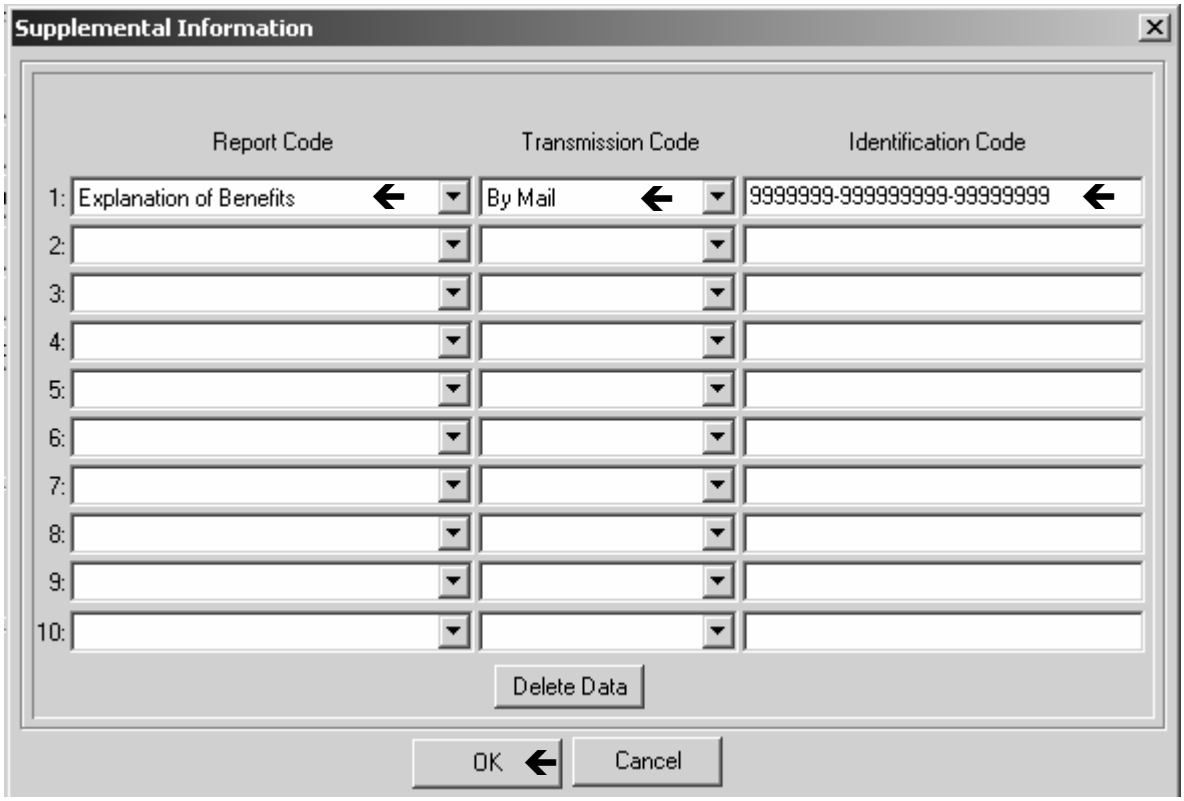
Referencing Paperwork Attachments & Blanket Denial Letters in a WINASAP Claim



For WINASAP claims where the provider needs to indicate that a separate paperwork attachment has been sent, or to reference a blanket denial letter on file in the TPL unit, please follow these instructions.

The black arrows on the screen images indicate required fields.

➔ Click on “Supplemental Info.”



The black arrows on the screen images indicate required fields.

➔ Under the Report Code pull-down menu, select the type of attachment, i.e., EOB. If the exact definition is not listed, select “Support Data for Claim.”

➔ Under the Transmission Code pull-down menu, select the appropriate code, e.g., “By Mail” for attachments sent by mail with the Paperwork Attachment Cover Sheet, or “Electronically Only” to reference a blanket denial letter on file in the TPL Unit.

➔ In the Identification Code field, enter the Attachment Control Number for attachments sent by mail with the Paperwork Attachment Cover Sheet. This number should consist of the provider’s ID number, client’s ID number, and date of service (mmddccyy), each separated by a hyphen. This number much match the Paperwork Attachment Control Number entered on the Paperwork Attachment Cover Sheet.

For claims referencing a blanket denial letter on file in the TPL unit, enter the reference number assigned by the TPL Unit. The format of this number is “TPL” + client ID number + carrier code with no hyphens between the three elements.

➔ When completed, click on “OK.”